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ABSTRACT

This monograph, the third in a series of five, provides training information for hospice staff in improving interdisciplinary team functions and humanistic care provisions. Its purpose is to describe the steps in designing a training program for a particular hospice and the activities undertaken between the selection of the trainers and the beginning of the formal training sessions. Chapter 1 provides a detailed discussion of the need for and purposes of the training. Chapter 2 states the goals and objectives of the training program. Chapters 3 through 7 describe the steps and alternative techniques in designing the formal training program. Examples and suggestions from the ELM Institute's hospice training experiences are found throughout. Several steps of the training design are discussed: data collection (purpose and procedures for staff orientation); data analysis and identification of issues specific to the hospice concerned; preparation of reports: feedback of the reports to the staff; confirmation and prioritization of issues, and the selection of staff as well as the selection, design, and planning of a customized training program to address these issues; leadership (use of alternate trainers, training methods, and types of leader activities in groups); and training program evaluation. Appendixes include tables of contents of the five monographs and data collection/interview forms. (YLB)

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THE ELM INSTITUTE
TRAINING PROGRAM DESIGN

Monograph 3 in a Series:

INTERDISCIPLINARY TEAM TRAINING AND
HUMANISTIC PATIENT CARE
FOR HOSPICES

September 1981

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MONOGRAPH 3

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FOREWORD

The ELM Institute is a not for profit corporation, founded to conduct research and education in established and emerging areas of health care delivery and policy. From the outset, one of the Institute's three major areas of interest has been terminal care, the others being cancer care and long term care of the impaired elderly.

While terminal care must function in the established health care delivery arena, its goals are substantially different. Instead of cure and rehabilitation, it acknowledges death and seeks to assure physical, spiritual, emotional and social comfort. We reasoned that this type of dichotomy would present organizational, structural, economic, and personnel difficulties as these two approaches were merged. These issues and their management are primary areas of interest to Institute staff.

For these reasons the Institute was pleased to receive the DHHS award to study the interdisciplinary team training and humanistic care training needs of terminal care programs. I believe the results contained in these volumes confirm our mutual judgment that alternative modes of health care delivery require unique staff interactions and support mechanisms in order to survive and meld with the current care system. Further, I believe you will find that the concepts utilized in this model for training and team development have broader programmatic applications than terminal care.

The Institute will continue to test and refine the model, and is willing to work with those programs who require specialized expertise or who face unique circumstances. In many other cases, it is our hope that these modules will provide sufficient information to an informed and experienced process consultant.

From the Institute's perspective, we intend to continue similar research and development projects in health care delivery and in policy formulation. We are pleased to have had an excellent opportunity to further our investigations and to work with an excellent group of advisors and collaborators.

Lee E. Mortenson
President
ELM Institute
Rockville, Maryland
August, 1981

PREFACE

Purpose of the Series

The purpose of this series of monographs is to assist hospices in improving their quality of care, through enabling them to improve their ability to meet the needs of their patients and families. Objectives include: improving the functioning of the interdisciplinary team, integrating the patient and family into the team, ensuring the appropriate utilization of professional services, and improving staff awareness and capability of providing humanistic patient care. These objectives may be attained through a training program for hospice staff described in the monographs.

The goals and objectives of the training program relate directly to those of hospices. Both direct attention to the whole person - patient, family member, or staff member - individually and as a group member. Both attempt to integrate the physical, psychosocial and spiritual approaches to care. Both combine scientific knowledge, skills, affective awareness, and interdependent coordination of activity to achieve an orientation to comfort and growth for all those involved. Hospices, having already made significant progress toward their goals, can expect the training program to enable them to approach these goals more quickly, more comfortably, and more effectively.

Hospice staff members need to be highly skilled in both the technical and the humanistic aspects of health care. These monographs acknowledge the need for high quality professional skill on the part of all staff members but do not address it. Training information in this aspect is assumed to be already in place. This series of monographs was developed to fill an acknowledged gap in training information for hospices, that is, training information in improving team function and humanistic care provision.

The monographs provide a significant contribution to these hospice activities. They provide factual information, approaches, and methods for qualified trainers to utilize their existing knowledge and skills successfully in the unique environment of the North American hospice. The series is intended primarily for the use of trainers assisting hospices, and not as a self-

help guide for hospices; however, all or parts of the series may be a helpful resource not only to hospices and hospice trainers but also to others concerned with the interdisciplinary and humanistic qualities of hospice care.

These monographs are working documents. The information they provide has been developed by trainers who are leaders in the field, tested in two demonstration hospices, and then modified on the basis of these tests. The developers anticipate that additions and variations will be appropriate over time and through continuing use of the document.*

Review of the Series

This series of five monographs was written by the ELM Institute under the general title: Interdisciplinary Team Training and Humanistic Patient Care for Hospices. The monographs, outlined below, address the following topics:

- Monograph 1: Guide for Hospices
- Monograph 2: Guide for Trainers
- Monograph 3: Training Program Design
- Monograph 4: Interdisciplinary Team Training:
Content and Methodology
- Monograph 5: Humanistic Patient Care Training:
Content and Methodology

Monograph 1, Guide for Hospices, is directed to hospice administrators. It may, however, be of interest to trainers and others. It describes teams, team function and the provision of humanistic patient care, and assists hospices to determine whether or not they have reached the state of development needed for this training. It identifies the objectives of the training and the anticipated benefits to the hospice, as well as the role of the hospice administration in the training and its financial and other obligations. In particular, it assists hospices to recruit and select one or more qualified trainers from outside the hospice organization to conduct the training. It also supplies useful suggestions to hospices based on ELM's hospice training experience.

Monograph 2, Guide for Trainers, is directed to "outside" trainers who may be invited by a hospice to conduct its training, although

* Reports of experiences with the monographs and any recommended additions or modifications to them would be welcomed by the developers - the ELM Institute, 11600 Nebel St., Rockville, Maryland, 20852 - for inclusion in future revised editions.

it may be of interest to others, as well. It is recommended that all trainers anticipating work in hospices read this monograph, regardless of their prior experience, in order to learn more about the unique features of a hospice and the implications of training in the hospice setting. The document provides background information about the hospice concept, models, components, standards, and staff characteristics. It also assists trainers to determine whether or not the hospice and the trainer match sufficiently well for the training to be successful, and to recommend the appropriate staff members to be trained. The role of the trainer is reviewed and suggestions from ELM's hospice training experience are offered.

Monograph 3, Training Program Design, is directed primarily to the trainer(s) who has contracted with the hospice to conduct the training. It will also be useful to hospices in working with the trainer in developing their programs. It may also be of value to others. The monograph provides a detailed statement of goals and objectives of the training, and describes the steps of the training design: orientation of staff, initial data collection, identification of issues specific to the hospice concerned, preparation of reports, feedback of the reports to the staff, confirmation and prioritization of issues, and joint staff/trainer selection, design and planning of a customized training program to address these issues. Again, examples from hospice training experience are reported.

Monograph 4, Interdisciplinary Team Training: Content and Methodology, is again directed to the trainer, although it may also be of interest to hospices and others. It contains the materials needed to conduct the training, and includes examples of issues and approaches to interdisciplinary team training in the hospice setting. It is not intended to limit the trainer but to assist by providing hospice information, outlines of successful training sessions, examples from hospice training experience, and relevant literature resources. It contains checklists and hints that may be useful to trainers, particularly in their first hospice training experiences. The monograph is divided into four sections, covering the major interdisciplinary team training categories: goals, roles, structure, and procedures.

Monograph 5, Humanistic Patient Care Training: Content and Methodology, provides trainers with information concerning humanistic patient care training in hospices and is similar in structure to that in Monograph 4. Again, although directed to the trainer, it may also contribute to understanding by hospices and others of the humanistic approach and what training in humanistic patient care entails. The document provides examples from hospice experience in humanistic values and orientations, in issues relevant to training, and in humanistic training in hospices. There are sections on background information, checklists and hints for trainers, and outlines of successful training sessions. Pertinent references to the literature are included. The monograph addresses the definition of humanistic patient care and the topics: psychosocial variables in working with dying patients; patient and family needs, environment and

rights; patient/staff relationships, including listening and stress management techniques; staff/staff relationships and staff relationships with other health professionals, including listening and communication skills; and monitoring of humanistic patient care provision.

It is not essential for hospices or trainers to acquire the complete series. Each monograph was prepared to address a different audience and to be complete in itself. This approach however, necessitated the inclusion in more than one monograph of certain sections common to more than one audience or title. The reader of the entire series will be well aware of these repetitions.

Review of the Project

This series of monographs was developed by the ELM Institute under a two-year contract with Health Resources Administration, Department of Health and Human Services, entitled: "Assessment of Staffing Patterns and Development of Interdisciplinary Team Training and Humanistic Patient Care in Hospices". The contractor was the ELM Institute, with David J. English, D.B.A., its Executive Director, the project director and Dottie C. Wilson, its Hospice Group Director, the associate project director.

A Panel of Consultants was named to provide technical assistance and to assist in the development of a training program plan and an evaluation plan. Some members of the panel conducted hospice training sessions. An Ad Hoc Review Committee was named, representing major health care associations and approaches, to provide a broad perspective to the work undertaken and to assess its applicability to the health care system.

An analysis was performed of documents describing the organization and staffing patterns, including staff characteristics, in current U.S. hospices. The documents analyzed were the more than 250 applications by hospices to the Health Care Financing Administration for waivers of certain reimbursement regulations. This analysis, along with bibliographies and assessments of the anticipated impact of training on hospices, was published in July 1980 in a report entitled: An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients.

ELM staff and Panel of Consultant members developed a training program plan, a statement of training goals and objectives, and, with the subcontractor, an evaluation plan. To test the plan, training was conducted in two demonstration hospices,

one an independent home care program and the other an inpatient and home care program within a hospital. The training was conducted by certain members of the panel of consultants with ELM coordination. Those trained included steering committees, a management team and patient care teams. The training was evaluated by the ELM Institute's subcontractor, Perry Cohen Associates, using both impact and process evaluation techniques.

Acknowledgements

The smooth conduct of the HRA contract and the significance of its results have been made possible by the availability and assistance of the HRA Project Officer, Mr. Thomas Aschenbrener. ELM appreciates very much his contribution to the success of the project and to the series of monographs.

All those who contributed to the project and to the series of monographs are listed in the Appendix to this volume. ELM extends sincere thanks to each of them, and in particular acknowledges the significant contributions of John A. Hackley, M.S.W., Mark S. Plovnick, Ph.D., Charles Seashore, Ph.D., and Terence F. VanOrshoven, Ph.D., to the development of the monographs.

The success of the training program demonstrations was in large part due to the enthusiasm, cooperation and support of the leadership of the two hospices concerned. Special thanks are due to Anne Kirschner Katterhagen, R.N., B.S.N., Executive Director of Hospice of Tacoma, Tacoma, Washington, and both Maryanne Fello, R.N., Director of Hospice Care, and Madalon Jmenta, Dr.P.H., Director of Research and Education, Forbes Hospice, Pittsburgh, Pennsylvania, for their interest and assistance in the training demonstrations.

The ELM staff, including senior associates, research associates, and support staff, have been most helpful throughout the project and monograph preparation. We appreciate it.

David J. English, D.B.A., Project
Director, and Dottie C. Wilson,
Associate Project Director.

September 1981

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CHAPTER I. INTRODUCTION

A. Purpose of the Monograph

The purpose of this monograph is to describe the steps in designing a training program for a particular hospice, and to describe the activities between the selection of the trainer(s) and the beginning of the formal training sessions. The monograph is directed to the trainer, although it will be of interest also to the hospice administrators who will be working with trainers in developing a training program specific to their hospices. It may also be useful to others interested in training program design.

Frequent reference has been made in the previous monographs to the need for and purposes of the training. Monographs 1 and 2 summarized the training program goals and objectives. This chapter, Chapter I provides a much more detailed description to assist the trainer in relating training issues to training program objectives. Chapter II provides the training program goals and objectives.

The remaining chapters of this monograph describe the steps and alternative techniques in designing the formal training program. These steps and the chapters they relate to are:

Chapter III

1. Establish the data to be collected.
2. Determine the technique(s) to be used in collecting the data.
3. Define those to provide data.
4. Orient the staff to the data collection.
5. Plan the data collection logistics.
6. Collect the data.

Chapter IV

7. Analyze the data collected.
8. Identify the issues relevant to training.
9. Prepare a report describing the issues.
10. Feedback the report to the staff.
11. Obtain staff confirmation of the issues.
12. Obtain staff prioritization of the issues.

Chapter V

13. Select the training topics to address the issues.
14. Determine the training program structure and logistics
15. Obtain hospice staff confirmation of the formal training program.

Chapter VI

16. Determine any additional trainers needed and define the training leadership activity.

Chapter VII

17. Define the training program evaluation.

Examples and suggestions from ELM's hospice training experience (both from this effort and ELM's years of prior hospice experience) are found throughout the monographs.

B. Rationale for a "Custom Design"

To be effective, the training program must address the specific needs of the individual hospice and its staff. The individual design for each hospice may be determined by collecting and analyzing data which identify the way the hospice and team function and the problems being experienced in providing high quality humanistic patient care.

As every experienced trainer knows, the process of developing an individual design requires the cooperative effort of the trainer, the hospice director (and other hospice administrative and management personnel), and the hospice staff, both those expected to participate in the training and those peripheral to it. This approach is needed to ensure that the data collected and the issues identified are correct, complete, and placed in order of importance or urgency. It is also important that the staff members to be trained participate in the planning of the training.

The following is a list of the problems some hospices face. It is given to provide an indication of the variety of issue areas that may appear during the training program design.

- Some staff members, such as social workers and therapists, are not utilized appropriately.
- There are conflicts between professional and volunteer team members.
- Patient care staff voice difficulties in teaching families to help care for patients.
- There are problems for staff in accepting patients and families as team members and as decision makers and evaluators of their care. Staff members may become angry when patients make decisions about their care which team members think are "bad" decisions.
- Some staff members do not trust each other to provide equally high quality care.
- Staff stress is acknowledged but skills to deal with it are not known.
- Some team members find role "blurring" or "blending" threatening and are angry that conventional professional roles do not continue to be clearly differentiated.
- The financial constraints of the hospice conflict with the quality of patient and family care provided, causing stress and frustration on the part of both administrative and caregiver staff.
- There are communication breakdowns between staff

members with the result that some important knowledge and details of care "fall through the cracks".

- Some staff members usurp the place of the family with the patient, while others are forced by the family to become its surrogate grievers.
- The personal beliefs of some staff members interfere with their ability to understand and accept the behavior of their patients.
- The spiritual needs of patients are not being addressed or met by some hospice staff.
- The demonstrated behavior and concomitant effects on the emotional needs of the patients of age, religious denomination, and ethnic background are not comprehended or taken into account by the staff.
- Some staff members are unable to prioritize the needs of the patient and those of the patient's family.
- Informality and flexibility, which reportedly pervade both inpatient and home care services to the terminally ill, are features regarded by both hospital and home care teams to be the hallmarks of their respective programs. Interviews and questionnaires revealed, however, that the absence of formal procedures at both the hospital and home care agency resulted in periodic ambiguity and stress for staff.

The issues identified for each hospice affect the training program goals and objectives which are chosen for the particular hospice. These goals and objectives are listed in Chapter II.

In addition to the myriad issues that may be identified in hospices, interpersonal problems and "personality clashes" may be major factors in determining appropriate training programs, their content, sequence, membership and leadership. Again, the age of the hospice and the maturity of its organization may be factors influencing its staffing and its staff interrelationships. The collection of information about the hospice, its history, and its staff is therefore a major step in the development of the formal training program. This is discussed in Chapter III.

CHAPTER II. TRAINING PROGRAM GOALS AND OBJECTIVES

The goals and objectives of the training program are stated below. They relate directly to hospice goals and objectives. Hospice attempts to integrate physical, psychosocial and spiritual approaches and to combine scientific knowledge, skills and affective awareness to achieve a comfort-oriented focus for both patient and family care. This focus may be identified as continuing care, appropriate care or humanistic care. Any stress-producing sense of dichotomy in the minds of staff members between the cure-oriented and care-oriented elements of professional patient care may be overcome through an interdisciplinary approach. A comprehensive look at the rationale for interdisciplinary team training and humanistic patient care training is given in the ELM Assessment Report.

The primary goal of the training program is to increase the capability of staff to improve the quality of patient and family care in hospices. This goal has two parts:

- To improve the functioning of the interdisciplinary team.
- To improve the staff capability of providing humanistic patient care.

Ten major objectives have been identified and are described below. For each, relevant references from the literature are given; the references themselves are listed at the end of this chapter. (In several instances, the same reference may be cited for more than one objective.)

Objective 1

To ensure that the mission (organizational statement) and the philosophy (beliefs and priorities) of the organization are defined and are understood by the staff, through attention to:

- Staff perceptions of the mission and their sharing of it.
- Staff and organizational philosophies of patient care.
- The policies and norms that support the mission.
- The knowledge of what is possible.
- Clarification of emphasis in professional patient care on the humanistic elements, attention to the whole person.
- The process by which the changes in mission or philosophy are communicated to staff.

(References: 1,2,3,8,9,10)

Objective 2

To assess, and modify if necessary, the mission, philosophy, and goals of the organization, of the team, and of individual staff members, to reach an overall congruity, needed through:

- Promotion of agreement or harmony between:
 - organizational mission
 - team mission
 - philosophy of care
 - management goals and decisions
 - staff attitudes
 - team procedures.
- Avoidance of cross-purpose activity.
- Resolution of stress-producing attitudes of staff toward external restrictions to the work environment over which they have no control.
- Development of broad and innovative approaches to humanistic care goals; and of methods of interfacing these approaches with more conventional concepts.
- Continuing attention to increased professional competency and improved quality of care.

(References: 2,4,6,11)

Objective 3

To maximize the utilization of staff, within the organizational constraints, with attention to the areas of:

- Utilization of available skills and competencies.
- Level of participation by all disciplines represented in the organization in:
 - the care plan and its modification
 - care provision, while avoiding duplication.
- Staff motivation to seek innovative solutions to complicated, multiple and overlapping problems of patients/families.
- Staff awareness of organizational constraints.
- Expansion of staff competence and stability through maximizing the opportunities for individual growth.

(References: 1,6,9,12)

Objective 4

To improve staff competence and satisfaction in person-to-person relationships with patients/families in the areas of:

- Acceptance of patients/families "where they are" (rather than where the staff may think they should be), their individuality and personal integrity.
- Understanding and interpreting patient and family behavior.
- Avoidance of evasion and deception in communications with patients and families (which would exacerbate their coping difficulties).
- Assistance to patients/families in their communicating with each other; group dynamics.
- Patient rights, and skills in communicating patient rights to patients/families.
- Creation of a caring environment where needs can be met without the patients/families feeling they are a burden.
- Learning from the patients/families.
- Normalcy and abnormalcy in patient/family beliefs and experiences, and skills in assessment and reassurance.
- Presence (to "be there" may be more appropriate than to say or do anything).

(References: 1,5,7,9,12)

Objective 5

To increase efficiency in the provision of care, without affecting the quality of care provided, through:

- Resolution of dysfunctional interpersonal conflict.
- Improvement of ability to confront conflict.
- Establishment of a structure to monitor conflict.
- Introduction of needed procedures, or increased clarity of existing procedures.
- Clarification of role definition.

- Increased acceptance of and participation in role-sharing.
- Reduction of duplication of effort.
- Expansion of knowledge of the relevant diseases/problems/conditions, and of the techniques for their treatment or management.
- Increased understanding of the process and progress of disease, what it does to people and how it limits people.

(References: 1, 2, 8, 10, 12)

Objective 6

To increase team cohesiveness, through attention to:

- Team function.
- Organizational discipline vs. individual freedom.
- Conflicts between organizational, team, and individual goals.
- Communication and sharing of feelings between staff members.
- Feelings of trust, respect and "positive regard" between staff members.
- Role clarification.
- Self-correcting norms, rules and procedures.
- Reward systems.
- Adaptation to changes in team membership.
- Group dynamics.
- Decision making (who, how, when) and team participation in decision making.
- Communication systems in meetings in terms of:
 - participation
 - outcomes
 - efficiency.
- Recognition that some people are not suited to or comfortable with team activity.

(References: 1, 4, 9, 10, 12)

Objective 7

To decrease perceived staff stress on the job, through resolution of:

- Attitude toward continual exposure to crisis situations.
- Difficulty in coping with the continual exposure to frequent and sometimes painful deaths.
- Tensions of frequently filling the role of surrogate griever.
- Feelings of guilt and personal inadequacy.
- Difficulties in dealing with families and with patients and families who disagree with each other.
- Interpersonal problems between staff members.
- Feelings of anger and blame, when, for example, symptom control is inadequate.
- Confusion because of the unclear definition of role, of what is expected.
- Disruptive team functioning because of environmental and/or structural factors.
- Difficulties in accepting decisions made by patients.
- Conflict between view of innovative hospice care and reimbursable care.
- Concerns about interfacing with standard health care and resolving medical and institutional misunderstandings.
- Problems in the areas of labor-management relations.
- Professional isolation from peers in the community and from staff in other hospices.

(References: 1, 2, 4, 6, 10, 11)

Objective 8

To improve the capabilities of the team and its members to manage their individual and collective stress, through the following:

- Management policies concerning:
 - hours of work

- time off
- open grieving
- provision of professional counseling.
- Staff-to-staff support systems.
- Team function and group policies.
- Team activities, including:
 - meetings
 - inservice education
 - staff development
 - social events.
- Professionalism vs. involvement, distancing.
- Individual coping mechanisms, including:
 - outside interests
 - teaching, public relations
 - personal health and fitness
 - spiritual resources.
- Congruity of goals.
- Emphasis on improved interfacing with peers engaged in conventional health care.
- Contact with staff in other hospice programs.

(References: 1, 9, 10, 11, 12)

Objective 9

To develop in the team the capacity for self-renewal, through on-going procedures in the areas of:

- Goal conflict resolution.
- Role definition and negotiation.
- Monitoring mechanisms.
- Interpersonal communication.
- Intragroup communications at meetings.
- Interdisciplinary group communications.

(References: 3, 10, 11)

Objective 10

To increase staff capabilities to teach and influence other organizations and to contribute to the state-of-the-art, particularly in the areas of:

- The emotional needs of dying patients.
- The effects on patient support of open communication and trust between patients, physicians and other health care personnel.
- Pain and symptom control techniques and the interrelationships between pain and anxiety.
- Techniques of functioning as an interdisciplinary team.
- The effects of incorporating the patient and family into the care team, as members and leaders.
- The capacity of patients for independence and self-identity, and staff perceptions of how this capacity can be actualized, increased and sustained.
- The adjustments of the family both to the physical and psychosocial changes in the patients during the dying process and to living without the patient.

(References: 1, 4, 5, 6, 7, 12)

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CHAPTER III. DATA COLLECTION

A. Introduction

Although experienced trainers would agree that the training actually begins at the time of the first contact, the data collection may be considered to be the first major step in the training activities. Stimulated by the interviews - or perhaps just by setting the appointments for interviews - staff members tend to think through their feelings and concerns and perhaps to discuss them with each other, with a new feeling of immediacy.

This chapter deals, first, with the purpose for data collection and the procedures for staff orientation to data collection. Then the what, who, where and how of data collection are discussed in terms of both principles and procedures. Examples and suggestions from hospice training experience are provided.

Steps 1 through 6 of the 17 previously listed are discussed in this chapter:

- Establish the data to be collected.
- Determine the technique(s) to be used in collecting data.
- Define those to provide data.
- Orient the staff to the data collection.
- Plan the data collection logistics.
- Collect the data.

It is essential that the data collection and the training design deal with both interdisciplinary team function and humanistic patient care, and that, if there is a different trainer for each section of the training, both trainers are involved in planning the data collection and its analysis. It is also important to note that, if there are different trainers for each section and if the humanistic patient care training follows the interdisciplinary team training, it may be necessary for the humanistic trainer to repeat or supplement some of the data collection and analysis to determine whether the humanistic section of the training as originally designed is valid or needs modification as of the time the humanistic training begins.

B. Data to be Collected

The interdisciplinary team and humanistic patient care training program can include training in a wide variety of topics. The topics most needed by each individual hospice are

chosen on the basis of the prioritized issues, problems of training needs being faced by that hospice. In order to learn these issues, problems and needs, and to recognize which ones are most in need of immediate attention, the trainer (or his delegate) needs to obtain information. The information needed concerns the hospice, its organization, its staff members, its patients and their families, the community it serves, and the organizations with which it works.

The kinds of data to be collected are listed below, grouped under four headings identifying types of data: environmental, organizational, patient care team, and individual care giver:

- Environmental Data

- Community demographics
- Referral sources
- Competition
- Reimbursement requirements
- Parent organization characteristics
- Legal requirements
- Manpower conditions
- External impact

- Organization Data

- Types of facilities/services
- Financial/utilization status
- Characteristics of founders and the Board (for independent hospices) or the institution's management (for dependent hospices)
- Configuration of patient care teams
- Personnel absenteeism/turnover
- Goal compatibility
- Leadership style
- Structural clarity
- Structural flexibility
- Interdisciplinary functioning
- Organizational process effectiveness

- Patient Care Team Data

- Cohesion
- Leader support
- Expressiveness
- Independence
- Self discovery
- Conflict management
- Knowledge skills existing and needed to make it uniquely prepared for hospice work
- Task orientation
- Order and organization
- Leader control
- Innovation

- Individual Care Giver Data

- Demographic characteristics
- Job history
- Religiosity
- Bereavement history
- Interpersonal style
- Job satisfaction
- Stress manifestations
- Professional involvement
- Attitude toward death and dying
- Perception of problems
- Suggested modifications to resolve perceived problems.

The greater the detail of data collected the more information there is from which to judge training needs, but also the more difficult it is to synthesize the real issues.

One overly simplified identification of the areas of data needed is found in the following three questions:

- (a) What do you do and how do you feel about it?
- (b) What are the major problems you have in making your contribution here?
- (c) What are the problems the organization has in achieving its goals?

C. Techniques of Data Collection

Basic to all data collection from staff members are the following principles:

- The sample size must be sufficient to be meaningful and to ensure confidentiality.
- Confidentiality of the data collected from each staff member must be assured. It must be clearly established who is in control of the data and who "owns" the results. Individuals must be assured that even if their words are quoted, these words will not be identified or identifiable.
- Data collection is not an end in itself but must be a preamble to action.

This section contains three sections:

1. Data Collection Techniques

There are many techniques for collecting data and a number of approaches in choosing the one most suitable

for the particular hospice situation. Five techniques are reviewed here, as follows:

- A formal written questionnaire or set of questionnaires, requesting specific information and opinions and feelings using validated test instruments. These questionnaires may be completed individually or in groups, at specific times under supervision or at any time (within a range). Written requests for general comments may be included in the body of the questionnaire (see Chapter VII).

This method provides quick, easily compilable data and is particularly useful if the number of data providers is large. However, expression of contentious feelings and candor of expression are minimized.

- Formal individual interview, following a pre-designed format, recording responses on an interview form. This method usually permits open ended questions and deviations from the format when appropriate.

Data collection by this method takes more time. The data is relatively easy to compile. It permits expression of opinion in sensitive areas, although the degree to which this is possible depends on the level of rapport built by the interviewer.

This method permits the interviewer to participate and to assess the candor or withholding of opinion of the interviewee.

- Informal interview, conducted without a structured format but with a series of questions in the interviewer's mind. Formal notes are not usually recorded, or are done after the interviewee has left. Questions are primarily open-minded and the interview is free flowing.

This method permits the greatest opportunity for in-depth comment and assessment. Its success is highly dependent on the skill and empathy of the interviewer. This method is probably not useful for collection of data from a large number of people. It can, however, be compiled and fed back more quickly than the other methods cited.

- Group interview, or staff committee data collection. Here, at regular staff meetings, the attendees are asked questions and encouraged to discuss in the group the problems raised. This can be structured as the completion of a mini-questionnaire by each group member, the scoring of these questionnaires immediately following completion, and group discussion of the results.

This method enables a skilled interviewer to determine quickly the major areas of need as verbalized by the group. However, the interviewer must hear intuitively the undercurrents expressed. It is unlikely that concerns in very sensitive areas will surface in this structure.

- Observation, performed primarily in regularly scheduled group meetings, without participation of the observer. Over time, the group may behave as if the observer were not there, and display their areas of training need. This method permits a true picture to be obtained, although time and a sensitive observer are prerequisites.

2. Choice of Suitable Technique

The choice of method should be a joint decision of the trainer and the hospice director (or other person in charge), or by the trainer in consultation with the hospice. Noting the advantages and disadvantages of each of the above methods, the most suitable method should be chosen for each individual hospice, based on the following considerations:

- Time available for data collection (in terms of the time constraints of both the hospice and the trainer).
- Amount of data that needs to be collected.
- Number of persons providing data.
- Cost of collecting the data.
- The willingness of data providers to participate.
- Skill and sensitivity of the data collector.

A decision that needs to be made also is whether the interview data is to be handwritten or tape recorded.

3. Examples from Hospice Training Experience

The data collection techniques used in ELM's hospice training experience included formal individual interviews, completion of questionnaires by interviewees, attendance at hospice meetings, accumulation of statistical data and hospice internal forms, job descriptions, informational brochures for the patients, families or the public, board and staff membership lists, and review of hospice procedures manuals and record systems.

Three groups of interview questions were developed for the three categories of interviews, that is, for the:

- Hospice director or administrator, which included questions concerning hospice history, policies and organization;
- Hospice staff members and volunteers, and
- Others, including board members, community leaders, referring physicians, institutional management representatives, and consumers.

These interview questions, which ELM revised during its hospice training experience, are presented in Appendices D, E, and F, to provide trainers with examples of one set of instruments. They are not intended to limit the trainer in any way in the development of his or her own data collection instruments.

In addition, Appendix G has a modified version that was used in working with three teams simultaneously: an oncology unit, an inpatient hospice consultation team, and a home care hospice team.

D. The Data Providers

Facts and opinions are needed from all those who will participate in the training and, in addition, those peripheral to them. These peripheral people may include board members or institutional management personnel involved in broad policy making for the organization, community leaders, hospice service consumers, and co-workers not participating in the training, if applicable, such as part-time special staff, office staff, and newly employed volunteers.

The provision of information, however is entirely voluntary. The conditions of the data collection and the assurances of confidentiality are therefore important in obtaining not only the consent to supply the data, but also honest, straight-forward, complete responses.

If the method to be used is the individual interview, each person significant to the functioning of the hospice should be interviewed individually. These interviews are confidential, follow a consistent format, and last approximately one hour each. Those interviewed may include, if available:

- The administrative director,
- The medical director,
- A random sample of referring physicians,
- Hospital officials (if hospital based), including the chief of staff, administrative director, chairman of department of medicine, chief of oncology, head of the department of nursing,
- A sample of members of the board of directors (if community based),
- Hospice supervisory staff, including inpatient coordinator, home care coordinator, chaplain coordinator, director of volunteers, and director of bereavement program,
- All hospice nursing staff, full and part time,
- Related staff such as social worker, nutritionist, physical therapist, other therapists, counselors, chaplains, and clergy.
- A random sample of lay volunteers,
- The directors of any community agencies being utilized in the program, such as the Visiting Nurse Association,
- Any students participating in the program,
- Some community representatives, and

- Others significant to the development of the hospice program.

If a written questionnaire or exercise is the approach used, all patient care staff members may be asked to complete these forms.

E. Staff Orientation to Data Collection

Data collection is conducted usually by the trainer (or trainers). Before the trainer begins any data collection, however, the hospice staff members as a group should be informed of the project and agree to contribute openly to the data collection.

Both the principles and procedure for staff orientation are described in this section.

1. Principles of Initial Orientation

Experience has shown that the most positive results are obtained if the following principles are followed:

- The hospice director (or other official who negotiated the agreement with the trainer) should inform the staff at a regular staff meeting. The trainer need not be present.
- The presentation should be made simply, with as little impact as possible, in order not to affect the data to be collected.
- The staff members must agree to participate in the data collection before it can be undertaken.
- Needless to say, the hospice director must not coach the staff members in their responses to the data collector's questions.

2. Procedure for Initial Orientation

- The initial orientation takes place at a regular staff meeting, preferably the one just prior to the beginning of data collection.
- The hospice director (or other official who negotiated the agreement with the trainer) describes to the staff the overall plan for the data collection and training program. Confidentiality of the sources of the data collected is emphasized. Any questions raised are answered, if the answer is known. No more information than is necessary is supplied.
- The hospice director solicits the cooperation of the staff in providing information and in being interviewed.

- A schedule for the data collection may be announced.
- Following this meeting, the hospice director contacts any staff members who were absent to advise them and solicit their cooperation also.

Once the staff members understand and agree to the project and the data collection, the data collection can proceed, utilizing one or more of the methodologies described above.

F. Data Collection Logistics

The data collection technique chosen by the trainer will determine the logistics of time and place. No arrangements may be required, or detailed interview scheduling may be necessary.

For individual interviews, the following checklist may be useful to the trainer and to the hospice:

- Determine who is to schedule the interviews (perhaps the hospice secretary).
- Establish who is to be interviewed (this may be a joint decision of the hospice director and the trainer). If random samples are to be performed, have this done and list those so chosen to be interviewed.
- Establish the number of interviewers and their availability.
- Determine the elapsed time required for the interviews (such as one hour each, or more for some and less for other interviewees) and for breaks for the interviewer(s) between interviews.
- Allocate, if desired, certain interviewers to certain interviewees (or the allocation can be unrestricted). It may be desirable, for example, if there are three interviewers and six hospice nurses to be interviewed, that each interviewer interview two nurses. Alternatively, it may be politically desirable for certain key hospice people to be interviewed by the most senior interviewer. There may be cultural or language reasons for special allocations also.
- Recognize that some interviews may need to take place at irregular times because of the work schedules of the hospice staff, particularly if the hospice has an inpatient unit with staff working shifts.

- Allow sufficient lead time for the appointments to be made, and sufficient total time to accommodate the schedules of those to be interviewed.
- For staff interviews, arrange for a quiet place that is convenient for the staff. A conference room, unused office, or patient room may be used; it should not be a room shared by others. Each interviewer needs to have a separate room.
- For institutional management and community interviews it may be more convenient for the interviewer to visit the interviewee's office. In this case, transportation to the location and time between interview appointments for travel may need to be arranged, if the location is some distance from the hospice.
- Arrange for a sufficient number of interview and other forms, if any, to be available, and for a writing surface for each interviewer (preferably hand-held, such as a clipboard) for use during the interviews.
- Review the methodology and approach with the other interviewers, if any, to ensure consistency, completeness and accuracy of the data collected.
- Ensure the confidentiality of the interviews and of the completed forms.
- Do everything possible to begin and end interviews on time. If one interviewee is late, try to shorten the interview so as to finish it in time for the next one.

G. Suggestions from Hospice Training Experience

Suggestions resulting from ELM's hospice training experience are provided here to assist the trainer in conducting the data collection phase of the training program.

It has been ELM's experience that data collection is time consuming and tiring. Interviews may be scheduled at 7:00 a.m. for a night shift nurse, throughout the day, and at 7:00 p.m. with a volunteer who works elsewhere during the day. If interviewers take copious notes, not only the brain but also the hand becomes fatigued!

Suggestions include the following:

- If many interviews are to be held, make sufficient notes concerning the appearance or characteristics

of each interviewee that you can identify the person and the interview questions during the compilation and analysis procedure.

- Frequently, the most difficult interviews to arrange are those with physicians - hospice medical directors, or referring and primary physicians. Once arranged, the physician may not appear, may be late, or may allow you only a short time. If there are questionnaires for the interviewee to complete, those of the physicians are likely to be not completed, or returned very late. Therefore, schedule the physician interviews before scheduling the others, and leave plenty of time in case he or she is late. Follow up frequently on any data (questionnaires, etc.) to be supplied by the physician to improve the chances of getting them at all.
- Be sure to interview the hospice director twice, if the format is similar to ELM's: once for the director questions and once for the staff member questions. The director is frequently involved in the logistics of the data collection, and somehow gets missed from the regular interview schedule.
- Confidentiality of data source includes the data supplied by the director. It also means sources of data collected from others is not communicated to the hospice director (or "client"). It is possible for ethical problems to arise in the relationship between the trainer and the client here.
- Approach interviewees with a warm, relatively informal manner in keeping with the style of the interviewee, and create a "safe" environment in order to obtain the most complete, reliable and meaningful data.
- At the beginning of the interview, review the purpose of the data collection and its confidentiality with the interviewee, and respond to any questions. At the end of the interview, review the interview process with the interviewee, to gain feedback and to be sure the interviewee is comfortable with the event.
- During the interviews, try to pick up on the problem areas expressed by one interviewee and question others in these areas later (without identifying the originator), whether or not the questions are on the question list, in order to determine how widespread these problems areas are believed to be.
- Compile and analyze the data as soon as possible after the data collection, both to ensure accuracy and to feedback the results as quickly as possible to those interviewed.

The steps in data analysis and feedback are discussed in the next chapter.

CHAPTER IV. DATA ANALYSIS AND ISSUE DEFINITION

A. Introduction

This chapter addresses steps 7 through 12 in designing the training program, namely:

- Analyze the data collected.
- Identify the issues relevant to training.
- Prepare a report describing the issues.
- Feedback the report to the staff.
- Obtain staff confirmation of the issues.
- Obtain staff prioritization of the issues.

Again, examples and suggestions from ELM's hospice experiences are included.

These steps should be accomplished in as short a time as possible - preferably no more than ten days - so that the staff members do not lose interest and momentum or become anxious about what they have divulged to the interviewer. Also, in an organization that is in a state of flux, it is important to present the issues as seen during the data collection before any unilateral organizational changes are made that negate or modify these issues and may perhaps create new issues.

B. Data Analysis and Issue Identification

The more data collected and the more people participating in its collection, the more complicated will be the process of analysis.

The data to be analyzed most carefully are those relevant to the proposed training. Opinions or information relating to other needs should not direct the analysis away from the problems the training addresses. For example, if hospice staff members state a need to learn more about ostomy care, this need may be noted but cannot be addressed as an appropriate topic for this training.

Performing the data analysis and identifying the relevant training issues does not lend itself to a step by step cookbook approach that could be successfully utilized. Instead it takes the application of analytical reasoning to a set of facts collected through the data collection instruments. ELM has found the following sequence of events most helpful:

- One day of interviewing following structured interview.
- Analyses of data collected and preliminary look at issue identification.
- On the second day, follow structured interview but emphasize those questions that would help develop issues more clearly.

- Crystalize statement of issues.
- Test out concept of issues by interviewing precisely on issue.
- Synthesize new data and finalize issue statement.

ELM follows this approach because ELM believes it is important that issues are tested so that one person issues do not become group training issues. In one program, for example, the speech pathologist thought communication between inpatient staff and home care staff was poor, and a major problem. In testing this issue, no one else found this issue significant.

The compilation of data should include total numbers or percentages or individuals who expressed certain opinions or who responded in a certain way to various questions. This method helps assure the correct weighting of information. Until this is done, there may be a tendency to assume that a strongly expressed opinion is more universally held than is actually the case. For instance, it would be important to determine whether it was eight percent or eighty percent of the interviewees who stated that they did not know to whom they reported.

It is useful also to differentiate interview data as to whether or not they are responses to questions or volunteered. The volunteered information may be considered the more significant to the identification of issues relevant to training. However, an analysis is recommended of the comfort level of the interviewee at the time such information or opinion is volunteered, as a variable in determining significant of the data.

Through the analysis of the data collected, the trainer determines the training issues, the way the hospice functions in its immediate health care setting as well as in the community at large, and the problems of the staff in functioning as an organization and as a team. An issue may be defined as a problem area that either itself requires change, or the conditions or circumstances that influence it require change.

The trainer draws upon data collected to discern the nature of the issue. Data may reveal very direct comments about problematic areas or may instead reveal a sense of discord in the environment, with those interviewed unable to discern what is truly bothering them. Issue perception is closely related to issue identification and analysis and the trainer must be wary of not creating solutions for issues which have not been agreed upon or defined by the group.

Issues relevant to training in hospices may cover a variety of areas: organizational, interpersonal, and individual. Some examples of staff problem areas which can indicate the existence of significant issues relevant to training are listed below:

- Personal goals of staff members and their relationship to team and organization goals,

- Attitudes of staff members toward each other,
- Agreement as to the membership roster of the team,
- Recognition by staff members of one discipline of the value of other disciplines represented in the team,
- Identification of gaps in the disciplines presently represented in the team,
- Integration of new team members into the team,
- Education of family members in patient care,
- Acceptance by staff members of decisions by patients concerning their own care, and
- Understanding by staff of the psychosocial aspects of aging and their relationship to the problems of older patients.

Examples of issues are presented in Monographs 4 and 5, under various training topics. For completeness, the following are a few examples of hospice training issues:

- "There is a perceived lack of clarity in the roles of selected members of the patient care team which leads to questions of levels of authority and possible under-utilization of consultant staff. Role ambiguity was particularly evident for the role of the medical director, inpatient head nurse, volunteer coordinator, volunteers, social worker, and patients/families."
- "There appears to be some unresolved staff/family conflict in the inpatient unit in terms of the family's level of participation in the care of the patient. There also appears to be some confusion about how to incorporate the family and patient into the team."
- "Conflict was identified between staff and management on the relative emphasis given to financial operationals and to the provision of high quality care for all patients in need regardless of financial capability. While staff has recognized for the most part the need for financial stability, there has not been real agreement on the balance between these goals."
- "The home care team, as reported, is not functioning as a team. Nurses, lay volunteers, home health aides, primary physicians, social workers, physical and occupational therapists, clergy/chaplains and the other personnel involved do not meet together and only minimally coordinate their activities."

- "The utilization of lay volunteers appears inconsistent across nursing personnel, based on figures provided by the staff. It may be possible that some nurses over-utilize and other nurses under-utilize the lay volunteers."
- "Identified educational gaps in knowledge areas were seen as affecting the staff's understanding of the patients and their families, the environment, and the choice of care modalities."

Some suggestions concerning issue identification may help the trainer in this process.

- Plan to organize the issues around the training topics described in Monographs 4 and 5. If possible, differentiate team issues from humanistic issues.
- Differentiate between management team issues and patient care team issues.
- Try to determine the basis of an identified problem, in terms of the exact training topic to which it most appropriately relates. For example, is a perceived conflict between financial viability and patient care quality a goal issue, an interpersonal conflict issue or an organization structure issue? (The decision in such a case may be a political one.)
- Omit issues that are not relevant to training.
- Identify issues that may require organizational change, that is, those that require decision making by those outside the group to be trained (such as the Board of an independent hospice or the institutional management of an dependent one).

C. Feedback Report Preparation

This section describes the preparation of the feedback report under the following headings:

1. Purpose of the Report.
2. Procedure of Report Preparation.
3. Report Approach and Language.
4. Hospice Training Experience.

1. Purpose of the Report

The trainer should prepare a report which presents the identified issues to the hospice staff. For purposes of this discussion a written report is assumed. An oral presentation may be made incorporating the same topics discussed here. The report has three purposes:

- To contribute information to the development of a training plan,
- To provide feedback to the team during the training sessions, and
- To identify any existing broad organizational issues, and to suggest directions the organization might take to solidify and strengthen its hospice program.

It must be recognized that all issues identified in this process may not be resolved through the training. However, recognition of the issues by both patient care staff and administration may in itself have an impact on their acceptance, if not their resolution.

Frequently, issues that have an impact on team function or humanistic care are so sensitive that only through an outside observer stating them can the entire hospice staff be comfortable enough to address these issues. A major benefit of this analysis to a hospice is seen to be the willingness of the staff to go through the process of identifying and concurring on the issues, and then agreeing to address the issues in a formalized training program.

2. Procedure of Report Preparation

The steps involved in writing the report, and preparing for its presentation include the following:

- Prepare an introduction, describing the concepts of hospice, interdisciplinary team function and humanistic patient care, and the relationship between these concepts.
- Compile the data into major problem areas, or issues.
- Review and assess the opinions expressed in the data relative to each issue.
- Document (in detail for a written report, in outline for a verbal report):
 - The importance of each issue
 - The majority opinions
 - The minority opinions
 - Special problems or aspects.
- Illustrate this documentation with actual quotations, unidentifiable as to source, from the data collected, to increase impact.
- Prepare enough copies of the report (if written) so that there is a copy for each participant at the feedback session.

3. Report Approach and Language

Whether trainer feedback to the group entails both a written feedback document and an oral presentation or only an oral presentation, the ability to provide feedback is a process, the effects of which must be continually monitored. The following guidelines may be helpful for increasing the awareness of that process:

- Provide your personal perceptions and descriptions of issues; acknowledge that they are your own perceptions.
- Describe behavior; do not interpret behavior.
- State issues in a non-evaluative fashion, if possible.
- Make specific statements.
- Present issues in a fashion which indicates the opportunity for change; do not presume things will change.
- Relate all issues to familiar group experiences.
- Target feedback to modifiable behavior and situations.
- Present feedback in a manner which motivates the group members to help themselves and which permits you to assist them.
- Be ready to deal with anger and conflict within the group.

4. Hospice Training Experience

Examples of issues are given above.

Each of these issue statements should be followed by a justification for it, such as a detailed explanation, a summary of examples, or a group of documented quotations from interviews. Two examples of a complete issue statement with discussion or justification follow. The format of each may be of interest also.

Example 1

ISSUE

Areas of tension with management as perceived by staff included lack of management understanding of staff case load pressures and of staff need for sharing feelings, lack of staff trust of management communications, and inadequate stress management skills.

DISCUSSION

These perceptions were expressed as follows:

- Perceived lack of management understanding of frustrations and stresses in the heavy case loads of care givers and in the continuing pressure to accept more patients.
- Inadequate stress management skills by staff as exemplified by "we-they" attitude of staff to management; inability to heal old wounds; lack of both enthusiasm and methodology to attempt solution to stressful concerns, and some overt backing off from these concerns.
- Lack of trust by staff of management communications; receipt of mixed messages.
- Insufficient acceptance by management of need for and allocation of adequate time for sharing of feelings and emotional support; lack of sensitivity to emotional needs of others, and to the need for positive strokes.

Example 2

Role of Spiritual and Religious Caregivers

The responsibility of staff and clergy for meeting the spiritual and religious needs of patients and families is not perceived to be clearly identified.

Present staff and volunteers report both hesitancy in initiating the subject with patients and families and lack of resource persons to provide the help needed. Some clergy do not go beyond providing sacraments in dealing with patients' spiritual and religious needs. Staff comments included:

"Patients pick up tones and attitudes here - there is not a tone of spirituality."

"We need spiritual care as a formal goal of the program."

"I want to be a part of the pastoral care program when it starts, to learn to respond better to different people from different cultures and with different religious beliefs."

"We need to pull into the team the patients' ministers, individually."

D. Feedback Report

It is essential that the feedback report be presented to those supplying the data to reach concurrence that the issues identified in the report are in fact valid and correctly interpreted, and to prioritize these issues.

The presentation of the results of the data collection should:

- Be made as soon as possible following the collection of the data, preferably no more than one week, and less if possible, and
- Include results on all areas in which data was collected, to meet the staff's expectations. If the results are not to be reported, the data should not be collected.

The process of giving and asking for feedback is one of the most important aspects of the training. It is through this initial feedback mechanism that hospice staff members will have the opportunity to view themselves as another sees them. Also, this process may affect the group's future receptivity to the trainer. Several themes should be implicit in the trainer's presentation of the feedback report, among them caring, trust, openness and acceptance. The trainer may find that there may be a tendency on the part of the administrator or the group to approach the issue identification and prioritization process as a "win-lose" proposition. The approach, however, is to achieve consensus as a goal through a "win-win" approach of collaborative problem solving (utilizing the concept of synergy).*

The form of the presentation may vary, depending on the data collection methods used, the time allotted, and the preferences of the trainer. Three methods are mentioned here:

- Verbal presentation, usually immediately following a "sensing" or relatively superficial data collection process, in which an overview of the issues is presented.
- Written report, reviewed in the presentation, usually approximately a week following a series of interviews with staff and others and a survey of other information sources. In this report, the issues are stated with supporting documentation.
- A series of posters, mounted on the walls of the room for review in the presentation, usually a few days following a series of "sensing" interviews. Each poster depicts an issue or a general theme supported by interview excerpts.**

E. Confirmation of Issues

This section discusses both the confirmation process and the steps in obtaining confirmation of issues by hospice staff.

* University Associates Handbook, 1973, La Jolla, CA, University Associates, 1973.

** Reilly, Anthony J., and Jones, John E., "Team-Building", in The 1974 Annual Handbook for Group Facilitators, San Diego, University Associates, 1974, page 232.

1. The Confirmation Process

Collaboration in the defining and eventual resolving of issues generates outcomes that are often more successful than the suggestion of any one member of the group. Consensus seeking can be viewed as hard work, requiring energy, and also as a rewarding activity, with members appreciating each others' contributions. The feedback session provides the first opportunity for the group to display its consensus seeking skills; the trainer thus gains additional information about the group.

Individual and group behaviors that the trainer may encounter in a consensus seeking session include:

- Arguing to win as individuals rather than seeking or accepting collective judgment.
- Viewing conflict on ideas, solutions, predictions, etc., as hindering rather than helping the process of consensus.
- Smoothing over all conflict prematurely rather than permitting the expression of some meaningfulness.

Issues may best be resolved when individual group members accept responsibility for both hearing and being heard, thus ensuring that everyone is included in what has been decided. Consensus seeking allows all members of the group to "get on board" and harnesses the group's resources to produce synergistic outcomes without denying the individuality of group members in this critical initial step.

Once consensus is reached, prioritization can begin.

2. Steps in the Confirmation Process

The steps in the confirmation process include the following:

- Meet first with the client: the hospice director (or executive director or administrator), to:
 - Review the report,
 - Obtain feedback concerning the issues identified, with additions, changes or confirmation,
 - Discuss any organizational issues that need to be modified and assist in the development of the modifications required,
 - Prioritize the activities needed to accomplish such modifications,

- Determine the groups to be trained in interdisciplinary team building and in humanistic patient care,
 - Describe next steps, and obtain agreement to present the report to the staff concerned, and
 - Confirm that the person identified as the client (usually the hospice director) is the person in charge
- Meet with the staff, including all those who contributed to the data collected and all those to be trained to:
 - Review the report, in particular the issues and the major areas of weaknesses identified,
 - Obtain feedback including additions, changes, amplifications and confirmation,
 - Obtain group consensus on the areas where training is needed, and
 - Confirm the groups to be trained in interdisciplinary team building and in humanistic patient care (as determined above).

F. Prioritization of Issues

Once consensus has been reached on the issues and the general areas where training is needed, prioritization of these areas is necessary, particularly if the time and funding for the accomplishment of the training is limited.

The steps in the prioritization process include the following:

- At the same staff meeting described in E above:
 - Obtain group consensus on the prioritization of issues in relation to group needs, and
 - Develop with the group a preliminary list of training topics and obtain the group's opinion as to the number of sessions, the best times for the sessions, and the order in which topics should be addressed.
- After the meeting with the staff, meet again with the client (the hospice director) to review the results of the staff session and to develop the training program plan.

Suggestions to the trainer in conducting the confirmation and prioritization sessions follow.

With the issues identified, confirmed and prioritized, and the general areas of training need jointly determined, the training program design is already underway. The design steps are described in the next chapter.

G. Suggestions from Hospice Training Experience

Experience has shown that the confirmation or consensus seeking sessions with the director and with the staff may be difficult for the trainer. Situations that may arise, and suggestions to the trainer concerning them, follow:

- The hospice director may feel insulted or angry, regardless of how carefully you worded the report. A clear "no" to what you consider to be essential changes in the hospice organization for the training to be successful will require your best skills in confidence building and negotiating.
- Alternatively, the hospice director may confirm the issues but may also assure you that the necessary changes will require decisions by others (such as the hospice board of directors) which will require so much time that the training will be delayed significantly - if the changes are, in fact, approved at all. It may be necessary to postpone the staff meeting and meet with board members or others to negotiate the changes or modify them.
- After working feverishly to write a reliable report within a few days, you may be discouraged to find that few hospice staff members show up for the feedback session. However, this may be an indication of their anxiety about the process.
- During the presentation, you may find that all session participants appear apathetic, agree with all issue statements without comment, and provide little if any feedback. It is possible, however, particularly after the review of the report is completed, that useful group discussion begins. Your facilitative skills may be utilized to the full in these sessions.
- Staff member comments that you have misjudged the issues may increase your frustration, since you may have "bought into" them yourself. However, if viewed dispassionately, these statements may develop into a discussion of real issues which were avoided during the data collection.
- Responses by staff members may be clearly protective of the hospice - or coached. It is necessary for you to restate your role and their "ownership" of the information.

With the issues identified, confirmed and prioritized, and the general areas of training need jointly determined, the training program design is already underway. The design steps are described in the next chapter.

CHAPTER V. DESIGN OF TRAINING PROGRAM PLAN

A. Introduction

This chapter is concerned with the definition of the formal training program, designed for the specific hospice to address the issues confirmed and prioritized by its staff. It deals with steps 13 through 15 in designing the training program, namely:

- Select the training topics to address the issues.
- Determine the training program structure and logistics.
- Obtain hospice staff confirmation of the formal training program.

These topics are discussed under the following headings:

- Training Design Methodology.
- Selection of Training Topics.
- Training Program Structure and Logistics.
- Confirmation of Training Program.

B. Training Design Methodology

How is the appropriate training for the particular hospice determined? Of the methods used by others in developing similar programs, the following quotation from the AMSA Foundation* Report is perhaps the most useful summary. Although clearly it refers to interdisciplinary team training for primary care only, extrapolations may be made to include also humanistic patient care training, and to relate to a hospice setting.

The Curriculum

Goals and Objectives

- a. An important perspective to maintain in developing the curriculum is that a team is not an end in itself, but rather a means to accomplish the task of delivering quality primary care.

* American Medical Student Association Foundation, Interdisciplinary Team Training Report, developed under DHEW Bureau of Health Manpower Grant No. MB-00104-01, 1978, page 137.

- b. Curriculum goals usually fall into the following general areas:
- 1) the development and use of skills related to health team development and maintenance;
 - 2) the acquisition of specific knowledge related to the professional training and skills of other disciplines and of an awareness of the roles and functions of those disciplines in the primary health care team;
 - 3) the use of the team approach to deliver comprehensive primary care that is adaptable to a variety of settings and will meet patient needs;
 - 4) content areas, such as family dynamics, patient-provider relationships, primary care, etc.
- c. It is important that the goals and objectives for the course be realistic in scope. A half dozen clearly defined, manageable objectives at the outset are preferable to an extensive list which creates frustration among the students and typically is pared down during the course.

Course Design

- a. The courses that appear to work best are those in which the didactic, team development and experiential portions occur concurrently within the course (rather than sequentially) and interrelate effectively with each other.
- b. Both subject matter and setting must be planned to ensure an active role for all participating disciplines.
- c. When interdisciplinary concepts are related to a significant task, students feel they have accomplished something worthwhile, and the experience becomes more meaningful and relevant for them.
- d. Faculty need to be prepared to deal with students' expectations for a traditional, tightly structured curriculum to which they are accustomed.
- e. Design changes almost invariably will need to be made during the course, and it is helpful for faculty to plan mini-evaluation sessions after each class (especially the first time the course is taught) and to involve students in a "mid-course corrections" session.

The Institute for Health Team Development* has published a useful list of major issues in conducting team development training, presented here for review by the trainer.

- A. Climate for learning should be supportive.
- B. Learning is a collaborative process between the faculty and student and as such there must be an open two-way communication/feedback channel between the participants in this process to assure that goals for the learning experience are being realized.
- C. There are different methods for teaching a content area depending on the level of learning required of the learner:
 - 1. knowledge
 - 2. understanding
 - 3. attitude
 - 4. behavior
 - 5. skill.
- D. The critical variables in health sciences education are the role models available to students and the setting in which the learning occurs, especially if this setting is a delivery site.
- E. Evaluation of the educational experience is critical to a creative approach to designing and implementing future learning experiences.

With these guidelines in mind, the trainer should review and analyze the prioritized issues of the hospice and draft the training program content for review by the client (the hospice director) and the hospice staff.

C. Selection of Training Topics

Utilizing the training topics covered in Monographs 4 and 5, the trainer should select those appropriate to the particular hospice and judge the time and emphasis needed for each, based on the prioritizations previously established. The major topic areas are described below:

* Introduction to the Teaching of Interdisciplinary Aspects of Primary Care: A Workshop, New York, Institute for Health Team Development, Montefiore Hospital and Medical Center, 1974, Section C, p. 4.

1. Choice of Training Topics

The training activity required could vary from one or two sessions on role negotiation or listening skills to an extensive program covering the entire range of topics in both interdisciplinary team building and humanistic patient care.

The major topic areas are listed below; within these some or all of the subtopics or session topics may be chosen:

- Goals of the hospice, the team and the individual staff members.
- Team structure and roles of staff members in the team.
- Organizational structure of the hospice, including its operational norms, climate and culture, and its relationship to team function.
- Procedures for decision making, problem solving, meeting management and communication.
- Content areas in humanistic patient care and relationships.
- Skills in listening, teaching, communication, stress management, and motivating patients and families toward their participatory role.
- Self-awareness, attitudes and values, and their effect on behavior.
- Continuing self-monitoring by individuals and team, and continuing transition of knowledge and skills to patient care.

2. Suggestions from Hospice Training Experience

Although the trainer and the hospice are entirely at liberty to choose and design their program, experience has shown the validity of the following guidelines:

- There should always be at least one session on goals, and it should be the first session. Otherwise, time may be spent in structural or role considerations that is not productive because of basic goal conflicts. Clarity and consensus as to goals is needed also before the humanistic patient care areas can be meaningful.

- Similarly humanistic patient care topics - in particular, skills and awareness - are confusing and difficult unless an opening session in this section of the training program deals with the group creating a working definition of humanistic patient care.
- Structured problems identified in the data collection need to be addressed toward the beginning of the training program, although solutions to these problems may develop slowly, as the training proceeds. Clearly solutions need to be reached by the team being trained and/or the hospice management for effective team function to be realized.
- Self-monitoring and the continuing transfer of knowledge and skills to improve patient and family care are topics that are best addressed as aspects of all training sessions rather than as a separate topic session.

3. Confirmation of Training Topics Selected

Continuing communication with the client (the hospice director) is essential in developing the training program. When the topics and sub topics have been selected, they should be confirmed with the hospice director. If there are major problems in the selection or negotiation of the training program content, the staff to be trained may need to confirm the selected program also.

D. Training Program Structure and Logistics

The program structure and logistics should be developed by the trainer and the client (hospice director) together, with input from the participants when necessary.

1. Scheduling

The total length and structure of the program should be determined, including the following:

- The sequence of topics to be covered,
- The number of training sessions,
- The length of each session (and the number and length of breaks),
- The time of day for the sessions,

- The frequency of sessions, and
- The date of each session.

The number and length of sessions may be a function not only of the amount of training to be accomplished and the workload of the staff, but also the financial resources of the hospice. Scheduling the time of day, frequency, and dates of each session can be a frustrating experience, attempting to coordinate the time schedules of the trainer(s) and all participants. All sessions need not be held at the same time, day, or frequency.

A schedule that has been successful in ELM's hospice training experience, and which is recommended to the trainer, is as follows:

- Eight to twelve interdisciplinary team training sessions, beginning with goals,
- Six to ten humanistic patient care sessions, beginning with definitions,
- Each session two-and-a-half to three hours in length, with at least one break,
- One session per week, or two every two weeks, morning or afternoon or alternating, (two sessions per week for communication skill training has been found useful),
- Two sessions for each topic if the participants are on shiftwork, and
- Perhaps a three to four week break between the interdisciplinary team training and the humanistic patient care sessions.

2. The Setting

The alternative locations and the criteria for choice of location will, of course, depend on the location available for the particular hospice. Guidelines for choosing the appropriate location include the following:

- The location should be the one most convenient for the largest number of participants. Frequently, the location of choice is the staff room or conference room in the hospice offices (in home care programs) and in or near the inpatient area (in inpatient/home care programs).
- It is not recommended that the training be held outside the hospice, such as in a university or similar setting or in a private home.

- The room should be set up in a round table or sitting room style rather than classroom style. The trainer should sit with the participants. (There are special room requirements for the communications sessions in the humanistic patient care training.)
- There should be a blackboard and/or flipchart readily available with plenty of chalk and brushes and/or paper and pens. Whether or not there is a blackboard, flipchart paper or other large sheets of paper should be available.
- Facilities should be available without difficulty for slide presentations (and perhaps also for films, if the trainer finds them useful).
- There should be plenty of coffee and/or other refreshments available, and facilities for replenishing supplies when needed.
- Washrooms and telephones should be conveniently located for use during breaks.
- The room should not be too warm, too cold, too noisy, or too garishly decorated.
- Parking should be readily available nearby.
- Strict instructions should be left at the hospice office that participants are not to be disturbed during training sessions. Arrangements need to be made for others to cover for the participants during this time.

E. Confirmation of Training Program

Continuing communication with the client (the hospice director) is essential in developing the training program. When the topics and subtopics have been selected, they should be confirmed with the hospice director. If there are major problems in the selection or negotiation of the training program content, the staff to be trained may need to confirm the selected program also.

The entire program, including topics, place, dates, times, etc., should be confirmed with the staff. This may be done by the hospice director if it should be difficult for the trainer to do so. It is important for the staff members to be enthusiastic about the training topics and to be able to fit the sessions into their schedules.

Although the training leadership in the training program may well be already determined, a review of leadership alternatives, roles and methodology comprises the next chapter.

CHAPTER VI. TRAINING PROGRAM LEADERSHIP AND METHODOLOGY

A. Introduction

Once the training emphasis and training program topics for a particular hospice have been identified and approved, the hospice should review the abilities and motivations of the chosen trainer(s) to conduct the training as defined. The role of the trainer and the assessment of trainers by both the hospice and the trainers themselves, as discussed in Monographs 1 and 2, should be reviewed in the light of this new information. Although it is unlikely that the chosen trainer or trainers would now be inappropriate, it may be advisable to add special trainers to lead sessions in particular topics.

This chapter addresses step 16 in training program design:

- Determine any additional trainers needed and define the training leadership activity.

This topic is discussed under the following headings:

- Alternate or Topic-Specific Trainers.
- Training Program Leadership Methodology.
- Training Program Leadership Activity.

B. Alternate or Topic-Specific Trainers

In designing the training program, the principal trainer(s) may need to consider the use of alternate trainers for certain topics. It is recommended that the trainer, rather than the hospice, choose such alternate trainers, because of his or her knowledge of the training program to be conducted. The trainer must, however, review his or her recommendations with the client (the hospice director) for approval before finalizing arrangements with such alternates.

1. Choice of Alternate Trainers

Guidelines to assist the trainer in the choice of alternate trainers include the following:

- If one trainer has been selected for the entire training program, this principal trainer may or may not be equally comfortable conducting training in interdisciplinary team function and in humanistic patient care. If not, he or she may wish to bring in outside assistance for some or all of the sessions in the less comfortable areas. Trainers providing such assistance should meet the assessment requirements described in Monograph 2, as did the principal trainer.

- Alternatively, the trainer may wish to bring in a specialist for only one or two sessions. This has been found to be a particularly valuable alternative in the humanistic patient care training, where a wide variety of knowledge and skills are needed to conduct all the topics. If the following topics are part of the particular training program, special session leaders may be needed:
 - Personal development, such as exploration of one's own and others' values, feelings, attitudes, and beliefs,
 - Knowledge areas, such as patients' rights, the psychosocial aspects of aging, illness or dying, and the implications of ethnic or religious/spiritual backgrounds, and
 - Skill areas, such as listening, feedback, of communication skill training.
- In seeking specialist trainers for particular topics, the principal trainer should seek those who will:
 - Fit into the methodological style and mood of the group already established by the principal trainer,
 - Fit the schedule for the topic(s) concerned, to avoid rescheduling and covering the topics out of their natural sequence,
 - Agree to provide feedback to the principal trainer on session process and outcome, and
 - Accept the established remuneration for the work to be done.

2. Maintenance of Continuity

The continued integrity of the group being trained and its continuity of purpose must be maintained regardless of the number of trainers conducting the training. If two or more trainers are involved in the training, a mechanism is required to maintain the group and to orient the alternate trainer.

The process of "bringing on board" a new trainer and the communication of information and insights between trainers before and after the sessions they conduct are important in the following situations:

- Change of trainers between interdisciplinary team training and humanistic patient care training. When both portions of the training program are conducted contiguously or with only a brief recess between, many of the issues raised and deemed "critical" in the interdisciplinary team training will continue to have a great deal of relevancy for the humanistic patient care training and may require further facilitation from an interpersonal perspective. As the time lapse between the two sections of the training increases, the value of much of the trainer shared information decreases because of the loss of relevancy and lack of timeliness.

- Use of trainers with specialized skills for specific topics. For some topics of greater specificity within the training program, a trainer with highly specialized skills or knowledge may be utilized to facilitate one or two particular training sessions. In the more sensitive topic areas, found particularly in the humanistic patient care training, alternate trainers need to know of any sensitive pressure points within the system. Having an alternate trainer prepared to deal with any dysfunctional behavior or sensitive issue will enhance the value of the particular session and will also minimize the potential for the alternate trainer to undo the work accomplished previously by the principal trainer.

3. Communication Between Trainers

Information should be shared between the two section trainers or between the principal trainer and the alternate trainer(s) at the time of transition (either to an alternate or back from alternate to principal). The information that needs to be communicated includes the following:

- Procedural Perceptions. These include an accounting of the departing trainer's approach in the group. This should include an indication of the group's level of knowledge and skill, an identification of issues raised and an assessment of the status of these issues in terms of both their resolution and their volatility.
- Functional Perceptions. These provide an indication of the key hurting points within the climate of the group. An assessment of group function may include: where anxieties are, what coalitions exist, who is hurting whom, and perhaps the emotional stability of individual group members. An understanding of the health of the organization and of the group helps the new trainer to discern whether the group is ready to proceed with change or represents a difficult target system.
- Personal Perceptions. These are the trainer's own professional opinions concerning the types of training activity or approach that could be employed with the group, based on his or her personal knowledge of and history with the group. A departing interdisciplinary team trainer may be able to make an informal assessment of the group's goals for humanistic patient care training. (The team trainer's last session with the group may include the identification of areas that need to be addressed in future training.)

This transfer of information is intended to facilitate continuity during the transition from one trainer to another.

The new trainer should use this information as a benchmark of the group's history and progress. It should be used in a discretionary fashion, not assuming it to be "gospel".

4. Alternate Trainer Appointment Procedure

In planning the training leadership for each session of the confirmed training program, the trainer should work closely with the client (the hospice director). Suggestions for alternate trainers may be made by each and both must approve the final decisions as to which sessions need alternate trainers and which alternate trainer should be chosen for each.

The selection of alternate trainers is affected not only by their ability to do the work but also by their:

- Availability for the established date,
- Acceptance of the task, and interest in participating with the particular hospice group,
- Respect for the principal trainer and willingness to fit into one slot in his or her program, and
- Agreement to the remuneration and arrangements offered by the hospice.

The invitation to the alternate trainer may come from the hospice or the principal trainer, whoever knows the alternate trainer best. There are advantages to the initial invitation being made by the trainer, in that he or she can best describe the group's needs, the methodologies being used, and the activity expected of the alternate.

The procedure in this case should be:

- The trainer makes the initial contact (probably by telephone), and obtains verbal agreement by the alternate to conduct the session or sessions requested.
- The hospice director confirms the appointment in writing, with the remuneration and any other arrangements clearly stated.
- The alternate would be expected to respond in writing accepting the appointment, and stating any materials, visual aids, etc. needed, and/or any reading to be assigned to the group preparatory to the session(s).

- Thereafter, communication with the alternate is continued by the principal trainer, who would supply background information and other data and opinions as discussed above.

If the hospice initiates the invitation, a verbal discussion between the trainer and proposed alternate should still take place before the written confirmation by the hospice. The remainder of the procedure remains the same.

5. Trainer and Hospice Responsibilities

Trainer responsibilities include:

- It is the responsibility of the principal trainer to orient the alternate trainer, assist in any way needed, to obtain feedback from the alternate trainer following the session(s), and, if appropriate, to provide feedback to the alternate as to the group's reaction to the session(s).
- It is also the trainer's responsibility to ensure that the alternate maintain the confidentiality of the activities within the group, the information supplied, and the sources of that information; any variations in this must be approved by the hospice director, the principal trainer and the group being trained.

Hospice Responsibilities include the following:

- Assuming the principal trainer does not attend the sessions conducted by alternates, it is important for a procedure to be established for meeting the alternate trainer, introducing him or her to the group, and making the session comfortable for both the alternate trainer and the group. (Transportation, hotel reservations, meals, assistance with visual aids, a tour of the facility, supply of expense-reporting forms, etc. may be involved.) The hospice should appoint someone, if it is not the hospice director himself or herself, to look after these details.
- A note of thanks to the alternate trainer from the hospice (or the principal trainer) may be appropriate.

C. Training Program Leadership Methodology

Considering the small size of the majority of hospice groups being trained, the informal, close relationships of most hospice staff members, and the nature of the training topics, it is anticipated that the lecture or formal presentation method will seldom be appropriate. Though didactic presentations may be utilized for several content areas offered in the training, empirical or experiential learning appears to fit the group to be trained more appropriately.

Useful training methods for interdisciplinary team and humanistic patient care training are summarized below. Although these methods are expected to be familiar to the trainer, they are presented here for the benefit of other readers and for the trainer's summary review.

- Affective learning. Affective learning implies emotional learning (as in the heightening of awareness) rather than cognitive learning, and includes exploring and generalizing feelings. It may refer to either individual or group learning.
- Simulated Laboratory Training. Rather than using actual patients/families for experiments with different styles of relating interpersonally, role playing activities are very beneficial. Group members have an opportunity to learn skills and then learn how to use those skills in role playing activities with other group members. This also frequently facilitates group members' increased levels of understanding and empathy for patients/families and for other group members.
- Small Group Dynamics. The use of small "task groups" has been demonstrated to be beneficial, particularly in the area of team development. Groups of two or three members may have responsibility for creating goal statements or delineating roles and functions of team members, and reporting them back to the larger group.
- Assisted Learning. The use of closed circuit T.V. and tape recording equipment provides direct and timely feedback to individuals participating in role playing activities. Closed circuit T.V., in particular, gives role players an impartial perspective about the physical, verbal, and non-verbal cues in the dynamics of a particular interpersonal encounter.

Other training leadership activities are described in the following section.

D. Training Program Leadership Activity

All trainers conducting hospice training sessions - both principal and alternate - should consider carefully their functions as group leaders. Sampson and Marthas* have developed a useful summary of the various types of leader activity in groups, identifying for each type of leader activity its purpose in group development and its affect on group members. This summary is shown in Exhibit 1; following.

Exhibit 1
Group Leadership

Leader Activity	Purpose of Activity
Supporting	Provides supportive climate for expressing ideas and opinions, including unpopular or unusual points of view. Facilitates members continuing with their ongoing behavior. Helps reinforce positive forms of behavior. Creates a climate in which silent members may feel secure enough to participate.
Confronting	Aids in growth and development; helps unfreeze members from being stuck in one mode of functioning. Helps reduce some forms of disruptive behavior. Helps members deal more openly and directly with each other.
Advising & Suggesting	Shares expertise, offers new perspectives. Helps focus group on its task and goals.
Summarizing	Helps keep group on its task by reviewing past actions and by setting agenda for future sessions. Brings to focus still unresolved issues.

* Sampson, E.E. and Marthas, Group Process for the Health Professions, Second Edition, New York, John Wiley and Sons, 1981, p. 258.

Leader Activity	Purpose of Activity
Clarifying	Organizes past in ways that help clarify; brings into focus themes and patterns of interaction. Helps reduce distortion in communication. Facilitates focus on substantive issues rather than allowing members to be side-tracked into misunderstandings.
Probing & Questioning	Helps expand a point that may have been left incomplete. Gets at more extensive and wider range of information. Invites members to explore their ideas in greater detail.
Repeating, Paraphrasing, & Highlighting	Helps members continue with their ongoing behavior; invites further exploration and examination of what is being said. Clarifies and helps focus on the specific, important, or key aspect of a communication. Sharpens members' understanding of what is being said or done.
Reflecting: Feelings	Orients members to the feelings that may lie behind what is being said or done. Helps members deal with issues they might otherwise avoid or miss.
Reflecting: Behavior	Gives members the opportunity to see how their behavior appears to others and to see and evaluate its consequences. Helps members to understand others' perceptions and responses to them.
Interpreting & Analyzing	Renders behavior meaningful by locating it in a larger context in which a causal explanation is provided.

Leader Activity	Purpose of Activity
Listening	Helps members understand both the likely bases of their behavior and its meaning.
	Summarizes a pattern of behavior and provides a useful way of examining it through the insights gained.
	Provides an attentive and responsive audience for those who participate.
	Models a helpful way for members to relate to one another; gives a feeling of sharing & mutual concern.
	Helps members sharpen their own ideas and thinking as they realize that indeed others are listening and concerned about what they are saying.

The choice of leader activity at each point in each group session requires experience and skill on the part of the trainer.

The impact of the training can be gauged by a number of informal indicators. These and more formal evaluation methods are discussed briefly in the next chapter.

CHAPTER VII. TRAINING PROGRAM EVALUATION

A. Introduction

This chapter addresses the last step, 17, in the training program design:

- Define the training program evaluation.

Evaluation strategies are discussed which can be carried out easily by a hospice and/or a trainer, and which provide pertinent information concerning training effectiveness. The chapter is divided into five sections dealing with:

- Informal Indicators of Training Effectiveness.
- Trainer Assessment of Training Effectiveness.
- Participant Assessment of Trainer and Training Effectiveness.
- Other Measurements of Training Effectiveness.
- Examples from Hospice Training Experience.

Results of evaluations are summarized and suggestions are offered based on this experience.

Training hospice staff in interdisciplinary team function and humanistic patient care may be assumed to be effective if it addresses the issues identified by the data analysis and confirmed by the hospice staff. Alternatively, nothing may be assumed and a full-blown impact and process evaluation may be undertaken. In this monograph, the approach is somewhere between these extremes: there is seldom time or financial support for a major evaluation project in most hospices, yet some substantial information is desirable as to the effectiveness of the training for the purposes of the hospice and its management which supported the activity, the trainer in planning future similar activities, and for other hospices and the health care system in general for future decision making in staff development.

Beckhard and Harris* have identified five key elements of an effective evaluation plan:

- Clarity and agreement about the purposes or priorities of the evaluation,
- Determination of required information and the selection of appropriate sources for the needed information,

*Beckhard, R., and Harris, R.T., Organizational Transitions: Managing Complex Change, Reading, MA, Addison-Wesley Publishing Co., 1977.

- Decisions about who will receive the data from the evaluation, who uses the feedback resources, etc.,
- Decisions on when to evaluate and the selection of data collection and analysis methods, and
- Determination of resources required and their availability.

These elements need to be kept in mind as an evaluation plan for the training program evolves through discussions between trainer and hospice director and, when applicable, the hospice staff.

It must be emphasized however that the evaluation should never jeopardize the major purpose of the training, staff development.

B. Informal Indicators of Training Effectiveness

Both the trainer and the hospice director (and, the hospice management) may feel elated or discouraged by the informal indicators reflecting the effectiveness of the training.

1. Examples of Informal Indicators

Informal indicators may include one or more of the following: (positive and negative responses can be gauged, although the following list is stated in the positive form

- Enthusiastic verbal responses to the training by participants.
- Full attendance at sessions, arriving on time, not leaving early.
- Utilization of newly acquired skills and approaches by participants, and use of newly learned words and phrases.
- Apparent reduced stress levels of participants, and more positive approach to new problems or crises.
- Increased "team spirit" of participants, including increased communication with and support of each other.
- Positive feedback from patients and families and/or from members of other organizations with which the hospice works.

- Ability of participants to care for more patients and/or to spend more of their time in patient and family care.
- Enthusiasm of participants in continuing the training sessions after the formal program has ended.

2. Pitfalls of Informal Indicators

Any euphoria seen during the training program needs to be tempered by consideration of the pitfalls of informal indicators, including the following:

- Is it a true observation or an interpretation?
The number of participants who are enthusiastic, attend the sessions, practice new skills, etc., should be carefully monitored. One or two very enthusiastic - or very upset - participants may unduly influence a hospice director or trainer into believing the same feelings are held by all participants.

Similarly, are the positive responses from patients, families and other really greater in number and in degree than those received previous to the training program?

- Will it last?
The level of enthusiasm, etc. should be plotted, however informally. There may be a positive response during and immediately following a session which dwindles until the next session, or it may remain at a high level constantly during the training and for a period thereafter and then disappear and the situation gradually return to its pre-training status. The response over time is more significant than that of the short term.
- Is it real?
Participants may verbalize the new language learned during the training but not actually use the concepts in their work. Are they really trying new approaches, practicing and improving on new skills?

With careful attention to their limitations, informal indicators can be useful evaluative tools for the hospice and the trainer. They are useful both for overall evaluation and for monitoring progress during the training program and identifying areas that need mid-course correction.

C. Trainer Assessment of Training Effectiveness

A useful tool in evaluating training effectiveness is an assessment form, completed by the trainer shortly after the conclusion of each training session. (The trainer who conducts the session - whether principal or alternate - completes the form.) The form is an instrument to assist the trainer in organizing his or her thoughts about the process of the session, and the progress of the group toward resolution of its issues, improvement in team function and humanistic patient care and reduction of stress. It can be helpful in planning the remaining sessions as well as in evaluating the program.

The form used during ELM's hospice training experience is provided in Exhibit 2. This form may be too detailed and too time consuming in its completion to be useful to most hospice training programs. However, it may be useful as a model in designing a more appropriate instrument.

At the end of each of the two sections of the training program the information on the forms can be compiled and analyzed as part of the program evaluation. It is not anticipated that this is the only evaluative tool used.

The pitfall here is the tendency on the part of the trainer to postpone completion of the form. The longer this work is delayed the less detailed and accurate the information will be. The trainer should make a commitment to complete the form within hours of the end of each session.

EXHIBIT 2

PROCESS QUESTIONS
Training Session No. ____

1. Goals of Session
2. Methods
3. Participants
4. Describe what happened (sequence of events).
5. What issues were raised? Which issues were dealt with? How? Which were avoided, postponed, redirected? Why?
6. Describe predominant attitudes of each individual and of the group during session.
7. List products of session (if any).
8. Describe content, attitudes and/or skills learned by group.
9. What issues/problems/content still need to be addressed (not already on future agenda)?

D. Participant Assessment of Trainer and Training Effectiveness

Since the purpose of the training is to have an impact on the participants (and through them on patient and family care), the assessment of the training by the participants is key to the program's evaluation. However, opinions may vary greatly both between participants and over time, and may be more or less honestly stated, so that the format for collecting this assessment tends to be less straight forward. Two methods are discussed in this chapter.

1. Session and Trainer Evaluation by Participants

As described in the Session Outlines in Monographs 4 and 5, there is expected to be a few minutes at the end of each session devoted to a group evaluation of the session. This process is useful to the group as a whole in identifying progress and problems, and the feedback to the trainer and hospice director (if the director is a member of the group being trained) is useful in program evaluation.

In addition, it may be desirable for each participant to complete an assessment form immediately following each session and hand it in. The value of such information would be a function of the comfort level of the participants in providing honest feedback in written form, for use of both the hospice and the trainer. If the information obtained in this way is valid, it should be useful both for mid-course correction purposes as well as for overall program evaluation.

Exhibit 3 is an example of a participant assessment form. In particular, participants should be asked to assess the objectives and if they were met, the value of the content, and the ability of the trainer.

2. Program Evaluation by Participants

Many more detailed and more time consuming methods are available for both impact and process evaluation of this training, such as that developed in ELM's hospice training experience.* Although an evaluation of this kind is not feasible for today's hospices, parts of it may be useful for the trainer and hospice director to consider.

One instrument that appears to measure some aspects of the training accurately is Organization Dimensions reproduced in Exhibit 4. This has been used as a pre-test, post-test and six month post-test instrument

* See Evaluation Section of Final Report of HRA Contract No. 232-79-0082, Washington, D.C., U.S. Department of Health and Human Services, Health Resources Administration, Public Health Service, 1981.

EXHIBIT 3

Session Assessment

Session # _____

Date: _____

Please indicate your answer by placing an "X" in the column opposite each question.

	Excellent	Good	Fair	Poor
1. <u>Trainer:</u>				
Knowledge				
Attitudes				
Teaching Ability				
2. <u>Content:</u>				
Practicality				
Quantity				
Clarity				
Relevance				
3. <u>Method of Presentation:</u>				
Quality of written material				
Quality of other teaching aids (if any)				
Number of speakers				
Acoustics				
4. <u>Opportunities for:</u>				
Discussion				
Input				
5. <u>Level of helpfulness to:</u>				
Respondent				
Others				

6. Additions, Deletions of changes in emphasis or content recommended:

7. Other comments (use back of page if needed). Are there things you would like to see the trainer do differently?

Exhibit 4
Organization Dimensions

Please circle the numbers which most nearly describe how you view the functioning of the organization on the following dimensions.

I. Direction

A. Goals:

clear	1 2 3 4 5 6 7	confused
conflicting among groups	1 2 3 4 5 6 7	shared among groups
members indifferent	1 2 3 4 5 6 7	members feel involved
supported by organizational procedures	1 2 3 4 5 6 7	not supported by organizational procedures

B. Leadership style:

autocratic	1 2 3 4 5 6 7	democratic
oriented toward task	1 2 3 4 5 6 7	oriented toward people
seeks change	1 2 3 4 5 6 7	maintains status quo

II. Organization

A. Power and Responsibility

task responsibility in the hands of one or a few	1 2 3 4 5 6 7	task responsibility shared by staff
tasks are fragmented among subgroups	1 2 3 4 5 6 7	tasks are well coordinated among subgroups
responsibilities are overlapping among professional disciplines	1 2 3 4 5 6 7	responsibilities are sharply differentiated among professional disciplines

B. Roles

management roles are clear	1 2 3 4 5 6 7	management roles are ambiguous
patient care roles are clear	1 2 3 4 5 6 7	patient care roles are ambiguous

C. Interdisciplinary Functioning

knowledge of other professions is low	1 2 3 4 5 6 7	knowledge of other professions is high
patient care decisions are made based on traditional professional role stereotypes	1 2 3 4 5 6 7	patient care decisions are made by those with appropriate information, knowledge and skills

III. Procedures

A. Communication

communication procedures
are confused or unknown 1 2 3 4 5 6 7

staff are always informed
about patient
status 1 2 3 4 5 6 7

communication procedures
are clearly understood

there are frequent misunder-
standings or lack of informa-
tion on patients

B. Decision-Making

decisions are made by
part of staff; others
ideas and opinions are
not heard 1 2 3 4 5 6 7

problems are not
diagnosed well 1 2 3 4 5 6 7

decisions are made by
consensus; deviant
information is used to
improve decisions

problems are accurately
diagnosed

C. Conflict Management

procedures to manage con-
flict are clear and
understood 1 2 3 4 5 6 7

differences are denied,
suppressed or avoided 1 2 3 4 5 6 7

conflict management
procedures are unknown or
confused

differences are recognized,
confronted and worked through

D. Incorporation of New Staff

the organization is closed;
new members are ignored
by the team 1 2 3 4 5 6 7

the organization is open; new
members are oriented quickly
into group activities

E. Monitoring and Evaluation

service activities are
carefully monitored and
discussed on a regular
basis 1 2 3 4 5 6 7

service activities are
never monitored
or
discussed

IV. Group Interaction

A. Cohesiveness

staff members rarely
work closely 1 2 3 4 5 6 7

I feel very much a part
of the staff 1 2 3 4 5 6 7

Patients and families are
incorporated into the care
giving efforts of the
staff 1 2 3 4 5 6 7

staff members always work
closely together

I feel outside the group;
not really a part of the staff

Patients and families
remain outside the staff
care giving effort

B. Rules and Standards

few rules, standards, norms
or sanctions are used to
guide behavior 1 2 3 4 5 6 7

all members follow norms
and standards of their
work group 1 2 3 4 5 6 7

rules and standards are
used to guide most
behavior

few members adhere to
group norms and
standards

norms and standards are
vague and subtle 1 2 3 4 5 6 7

norms and standards are
adaptable to changing
conditions 1 2 3 4 5 6 7

C. Trust

interactions among the
staff are open 1 2 3 4 5 6 7

feelings are not freely
expressed as part of
staff interaction 1 2 3 4 5 6 7

norms and standards are
explicit and known

norms and standards are
rigid

interactions among the
staff are careful and guarded

feelings are freely
expressed and receive
empathic responses

V. Outcomes

A. Task Achievement

staff interaction often
hampers task achievement 1 2 3 4 5 6 7

staff interaction usually
helps task achievement

B. Productivity

group meetings usually
accomplish what is
necessary 1 2 3 4 5 6 7

group meetings usually do
not accomplish what is
necessary

all staff resources are
used effectively by the
organization 1 2 3 4 5 6 7

many staff resources and
skills are not used by
the organization

C. Creativity and Growth

staff handle most tasks
by routine procedures 1 2 3 4 5 6 7

staff are flexible and
seek new and better ways
to work

VI. External Conditions

regulatory requirements
place severe constraints
on the flexibility of
professional roles 1 2 3 4 5 6 7

regulatory requirements do
not hamper role flexibility
among professionals

outside organizations play
a major part in setting
the direction of the
organization 1 2 3 4 5 6 7

outside organizations have
limited impact on the
organization's direction

reimbursement require-
ments have limited impact
on the work 1 2 3 4 5 6 7

reimbursement requirements
place severe constraints on
the way work is done

successfully. The drawback may be, however, in compiling the data without benefit of a computer. It was found most useful when staff were asked to retrospectively complete based on where they were when program began.

Alternatively, the participants and others may be interviewed following the completion of the formal training program - or following the completion of each section of it. This is particularly useful if the data collection interviews were conducted by others instead of or along with the trainer, and if these "others" conduct the post-training interviews; then the participants are likely to feel freer to express their opinions and concerns.

E. Other Measurements of Training Effectiveness

Several other evaluation methods may be appropriate, particularly those which involve numbers being accumulated and compared. Examples include the following:

- The staff turnover rate for the year before and for the year after the training (as a measure of staff member job satisfaction).
- Staff absences for the same two periods, particularly absences due to illness (as a measure of staff stress levels).
- Staff attendance at staff meetings for the two periods (as a measure of staff enthusiasm and interest in the hospice and the patients).
- Number of disciplines (including volunteers) represented in the care of each patient and family totalled for all patients (on the assumption that the greater the number the better the patient and family needs are being met).
- The pain level of patients as measured by simply pain charts completed by the patient or family (on the assumption that a reduction in the average pain levels for all patients indicates improved patient care).
- The average length of stay of patients (on the assumption that a longer LOS indicates referrals are being made more appropriately as a result of better hospice-community relations).
- Number and dollar value of donations to the hospice (as a measure of consumer satisfaction with the care provided).

Undoubtedly the hospice and the trainer will be able to add to this list. It is important to note that the most useful and easily compiled data are those that are already being collected, with figures already available for the year prior to the training. If one of the proposed measurements has not been performed previously but can be begun at the beginning of the formal training program, this information may still be useful as a measurement of change through time.

F. Examples from Hospice Training Experience

Although a relatively simple evaluation system is suggested for this training, trainers and hospices may be interested in some of the results of a more comprehensive evaluation of one hospice interdisciplinary team training program in ELM's experience. Four months after the completion of this section of the training, the evaluation identified approximately fifty positive indicators of the impact of the training. These were grouped into four areas:

- Structural changes of work groups,
- Clarification of direction and operations,
- Process changes, and
- Outcomes.

As examples of these indicators, the outcomes (the fourth grouping) included the following:

- More outreach to community physicians,
- Increased responsibility and control by nurses over patient care provided by team,
- Reduced burden on nurses by increasing responsibility of aides, volunteers and chaplains in in-home care (more delegation, clearer assignments, more referrals),
- Reduced load on home care coordinator (increased responsibility of nurses),
- More coordination of care (more information, better defined tasks and constraints),
- Higher visit count and more revenue (from clearer roles and referrals, and greater acceptance of reimbursement constraints),
- More trust between staff and administration, and
- Much less stress related to organizational concerns, and
- More energy devoted to patients and families.

Clearly, evaluation results in other hospices would not be identical to this one, since outcomes are functions of each hospice's identified issues. However, such a statement of outcomes may be an indication to hospices and trainers of potential benefits of such training.

In ELM's hospice training experience, the effectiveness of the interdisciplinary team training was more readily evaluated than that of the humanistic patient care training. The humanistic training apparently has a snowball effect and, although it tends to take longer to produce a clear and measurable impact, the impact increases over time. This positive humanistic patient care training result, in ELM's hospice training experience, is felt to have been in part a function of this section of the training following the interdisciplinary team section, and, in turn, reinforcing it. Such an effect could not be anticipated if the humanistic patient care training had preceded the interdisciplinary team training.

Once the training program design is completed as discussed in this chapter, it is important for the formal training sessions to begin as quickly as possible. The content and methodology for each of the two training sections are described in Monographs 4 and 5. These monographs provide information for the trainer concerning hospices and hospice issues, as well as background information for trainers, suggested session outlines, and selected references from the literature.

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APPENDIX

- A. Definitions
- B. Contributors to the Series
- C. Table of Contents of Five Monographs
- D. Interview Questions - Hospice Director
- E. Interview Questions - Hospice Staff and Volunteers
- F. Interview Questions - Community
- G. Modified Version - Multiple Teams

APPENDIX A

DEFINITIONS

Meeting the needs of terminally ill patients and their families requires an interdisciplinary and humanistic approach to care. "Meeting needs" infers that the patients and families communicate their needs, directly or indirectly, and that the staff members understand the communication. Staff members also independently recognize patient and family needs and can help them to acknowledge unrecognized yet real needs. The staff then makes every effort to find approaches to meeting the needs.

The patient is recognized as a person with decision making, planning, care delivering and evaluating powers. The family is viewed in the same way. Both patient and family understand their rights and realize that they are in control. They also recognize that they are capable of personal growth through the dying experience. Humanistic patient care is this approach by staff to patients and families. It includes state-of-the-art professional physical care and psychosocial and spiritual support of patients and families as they maintain their independence and their preferred way of life and death.

As the needs of terminally ill patients and their families may be in multiple areas, multiple skills and disciplines must be utilized in any attempt to meet them. The approach, then, must be multidisciplinary. As these needs overlap for the patients and families, and as the solutions to some needs may conflict with solutions to other needs of the same patient and/or family, an interdisciplinary approach is needed. As no one person or profession can meet all the needs, and as no one person can successfully cope alone with the stresses inherent in this work, a team approach is indicated. The patient and family participate as team members. An interdisciplinary team, providing input into assessment, decision making, care and evaluation, with blurring of traditional roles and mutual information sharing and support, has been found to be a most effective approach to terminal care.

1. Interdisciplinary Team

Team activity is not confined to health care nor to any one specific structure. There are board member teams and management teams as well as staff teams. Teams may have consistent membership or may have rotating members; team members may work together with frequent team meetings, or they may seldom meet face to face. Teams may be made up of members of one profession or discipline, or may include more than one profession or a mixture of professions and disciplines. An interdisciplinary team

has been defined by Ducanis and Golin* as "a functioning unit, composed of individuals with varied and specialized training, who coordinate their activities to provide services to a client or group of clients". Rubin, Plovnick and Fry** add that coordinating activities requires teamwork. "This need for coordination and working together is called 'interdependence'. Any job that cannot be done by just one person requires some degree of interdependence." (Hospice interdisciplinary teams are discussed at greater length in Monographs 1 and 2.) The Health Resources Administration has defined an interdisciplinary health team as follows:

INTERDISCIPLINARY HEALTH TEAM is composed of three or more health professionals, including physicians and physician's assistants or nurses, who relate on an equal non-hierarchical basis to each other in the provision of health services to primary, secondary and tertiary care patients. Usually such teams have received didactic and experiential training concerning the roles of other health professionals, interpersonal communications, small group process, other organizational development concepts, and patient/provider relationships. The patient and the patient's family are considered members of the interdisciplinary health team, along with the physician and such staff as physician's assistants, pharmacists, clergy, social workers, psychologists, administrators and volunteers as appropriate.***

2. Humanistic Care

Humanistic patient care is a term used to describe an activity that evades clear definition. In hospice, it has been defined as a timely comfort-oriented focus for patient care and

* Ducanis, A. J. and Golin, A. K., The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, page 3.

** Rubin, I. M., Plovnick, M. S., Fry, R. E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Co., 1975, page 3.

*** Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

family care delivery . It indicates an increased emphasis on the non-scientific elements of professional patient care (without reducing emphasis on the scientific elements).

The Health Resources Administration has defined humanistic patient care by reference to a definition of humanistic medicine:

HUMANISTIC MEDICINE is medical practice and culture which respects and incorporates the concepts that: the patient is more than his disease, the professional more than a scientifically trained mind using technical skills, both are whole human beings interacting in the healing effort, a person is more than his body, he is a unique, interdependent relationship of body, mind, emotions, culture and spirit; each person has the capacity to define and be increasingly responsible for himself, the professional seeks to assist the patient in taking and fulfilling his responsibility for himself; health and disease are not matters of the moment but have intricate past, present and future; disease, physical, emotional or spiritual pain and suffering, aging and death are meaningful events in an individual's life; and effective health care requires not just conventional skills but also effective development and use of human qualities such as intuition, inventiveness, and sympathy.*

3. Other Definitions

Operative definitions of other terms used in the monographs are provided to ensure clarity of content:

ORGANIZATION DEVELOPMENT (O.D.) means "an evolving collection of philosophies, concepts, and techniques, which aims at the improvement of organization performance by intervening in social systems (the patterns of social relations existing within a formal organization). Attempted changes may be directed at individuals, dyads, groups, intergroups, formal structures, or cultures. O.D. is not yet a coherent applied science. It derives more from the social than the biological

* Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

or physical sciences.**

FACILITATION/FACILITATOR. The verb to facilitate refers "to a process by which events are 'helped to happen'. Facilitating is a kind of influence role which is neither authoritarian, on the one hand, nor abdicative, on the other."**

TRAINER in this series of monographs means the formal leader of the training program sessions, as well as the person conducting the data collection, data analysis, and training program design. This term is used throughout, even though this person is facilitating staff development rather than teaching technical knowledge and skills. As it is recommended that this person be found outside the hospice setting, the person is acting as a consultant to the hospice. The term trainer is used here, therefore, in lieu of the terms consultant, facilitator, process person, change agent, O.D. specialist, or leader.

EXPERIENTIAL AND AFFECTIVE LEARNING. Experiential learning means learning through experiencing within the group, and then analyzing and generalizing from the experience. The experience may be actual or simulated (through role playing, or through video taping of group members' interactions). It refers to experiences presently taking place within the group members (not reporting of experiences that have taken place with others). Affective learning implies emotional learning (as in the heightening of awareness) rather than cognitive learning, and includes exploring and generalizing feelings. It may refer to either individual or group learning.

* Vaill, P. B., "An Informal Glossary of Terms and Phrases in Organization Development", in Jones, J. E. and Pfeiffer, J. W. (editors), The 1973 Annual Handbook for Group Facilitators, La Jolla, CA, University Associates, 1973, reprinted with permission in Weisbord, M. R., Organizational Diagnosis, A Workbook of Theory and Practice, Reading, MA, Addison-Wesley Publishing Company, 1978, page 75.

** *ibid*, page 73.

APPENDIX B

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APPENDIX C

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HOSPICE INTERVIEW FORM - DIRECTOR

Page 1

Interviewee Names(s):	Hospice Name:
Job Title(s):	Date of Interview:
How long worked here?	Inter- viewed by:
When was this hospice incorporated (or formally established)?	
Is the hospice licensed? _____ If so, as what? _____ By what agency?	
When did each hospice component begin (Home Care, Inpatient, Bereavement, Education)?	
Who was (were) the Founder(s)?	
What was the Founder(s) motivation to do this?	
What is the Founder(s) current role?	
<u>If incorporated:</u> composition, background and outlook of current Board: <u>(If part of larger institution: type and size (beds, patients, staff), and distinctive characteristics of the larger institution)</u>	

Community structure; including size, composition (including spread, style and language of predominant ethnic and religious groups), characteristics (rural, service, industrial), leadership and dominance:

Area and population served by the hospice:

Are there other hospice programs in the community (names, components, areas served)?
(Do they compete with this hospice?)

What are the hospice's primary referral sources? (physicians, hospitals, nursing homes, home health agencies, other providers, families, patients, etc.)

What is the total number of physicians who refer patients to hospice; what is the number who regularly refer; what are their specialties; what is this as a percentage of the total of these specialties and of the total physicians in the hospice's service area?

How many physicians referred patients in the last three months? _____

What is hospice's relationship to professional associations? Is the hospice recognized as a separate activity? Do they restrict the hospice's activity? Are relationships cooperative or antagonistic?

What is hospice's relationship to regulatory agencies (state, local)? Is hospice recognized as a separate activity? Are relationships cooperative or antagonistic?

Does the hospice have affiliations with: (names and affiliations and whether formal or informal, joint, on-going, and roles of each) Are resources shared?

Community Hospitals?

Teaching Hospitals?

Home Health Agencies?

Nursing Homes?

Universities (educational)?

Pharmacies?

Other community resources:
(equipment, meals, transport, etc.)

Other:

What organizations in the above categories are there that the hospice does not have affiliations with? (names and categories of organizations in the hospice's service area) Why? (competing, goal conflicts, no terminally ill patients, etc.)

With which third party payers does the hospice have contracts?

What percentage of costs are reimbursed by third party payers? Is this expected to change?

How cooperative are the third party intermediaries?

What relationships does the hospice have with other funding sources? (foundations, government agencies, local charities) Is it a HCFA demonstration project? _____ Does it presently have grant funds? _____ Does it regularly receive funds from local charities? _____ Does it have representatives on the Boards of local charities?

What percentage of costs are covered by these other funding sources?

Does the hospice receive memorial donations and private donations from families? What percentage of costs are covered in this way?

What other sources of funds are there? What are your major funding problems? How do you plan to address them?

What effect do reimbursement regulations have on staff activity? (time to complete reports, decisions as to types and numbers of visits)

What are the hospice's financial control procedures?

What are the goals of this hospice?

Are these goals constrained by environmental factors, such as reimbursement restrictions? _____ If so, how?

What is the supervisory structure and organization chart of this hospice? (both administrative and functional, if there are two charts):

For your hospice's present program components (home, inpatient, bereavement, education, etc.), please describe each one briefly (Inpatient: number of beds, facilities, hospital relaxation of regulations re: visiting etc.) (Home care: 24 hours/day, 7 days per week coverage, primary care person in home required, professions providing home visits, etc.)

Are there written job descriptions available? _____ for all positions or some only? _____ for volunteers? _____ (please supply copies of all job descriptions)

Do these job descriptions accurately reflect functioning? _____ If no, describe differences: _____

In which of the following positions are there presently vacancies (✓) and if/when will they be filled:

Medical Director _____	Social Worker(s) _____
Exec. Director (Administrator) _____	Nutritionist (Dietician) _____
Nursing Director _____	Pharmacist _____
Bereavement Director _____	Therapist (OT, PT, ST) _____
Volunteer Coordinator _____	Recreationalist _____
Spiritual Coordinator _____	Volunteers _____
Education Coordinator _____	Staff Support Person _____
Nurses _____	Aids/Homemakers _____

Total number of vacancies _____

What are the hospice's recruiting policies and methods?

Have there been any problems in recruiting staff (quantity and quality)?

What are your required qualifications for professional staff, and selection criteria for all staff and volunteers? (are these specified in the job descriptions? _____)

What is your procedure for selecting staff and volunteers?

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INTERVIEWEE(S) _____

What are the hospice's personnel policies (pay, benefits, time off, incentives, performance review)?

What is your turnover rate for paid staff and for volunteers? (Number of times per year a new person fills each position by job title)

What is your growth rate? (Number of new positions filled per year as a percentage of total positions)

What is your absentee rate, by job title? (person days absent as a percentage of total working person days)

How do you rate perceived staff stress levels at the present time?
(Is this about the same as usual? _____ If not, why?)

Are the staff formed into a team or teams? _____ If yes, does the patient care team change for each patient? _____ If yes, how is each patient care team determined (what procedure is used)? Are there problems in establishing teams? _____ If so, how do you solve them?

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INTERVIEWEE(S) _____

Please describe each regular staff meeting (including volunteer meetings):

Purpose	Frequ- ency	Dura- tion	Leader- ship	Attendees

Describe the hospice's orientation program for new staff and for new volunteers:
(supply materials if available)

Please identify, by name and job title, the members of the (or of each) team:

Describe the hospice's in-service education program (if any) for staff and volunteers: (show schedule for last month and for next month, content records, attendance records, and make-up session records) (supply materials, if available)

How well have each of the following topics been covered for all staff members?

- description of humanistic patient care: _____
- comparison of this with conventional care: _____
- knowledge of symptom control: _____
- knowledge of patient rehabilitation, physical restoration, maintenance of independence, activities of daily living, and self actualization (including the role of occupational and physical therapists) _____
- environmental factors that contribute to the level of success of the team and the individuals in it _____
- awareness of the emotional problems involved in dealing with death: _____
- psychosocial implications of illness, death and aging: _____
- effect of religious beliefs and cultural background on patients' and families' reactions to death, illness and aging: _____
- skills in listening, teaching, group process, stress management: _____

What additional topics do you feel the staff need or want to have included in the inservice education program?

What is the hospice's policy regarding guests and media people visiting the hospice for their education (and for publicity)?

What future problems, if any, do you see in staffing (known or anticipated resignations, regulations or other changes)?

What future plans, if any, does the hospice have regarding staff (increase or decrease in number, addition of new professions, addition of new hospice components, changes in emphasis, etc.)?

What is your current nurse-patient rate (inpatient care)? Total of RN's, LPN's, aides, orderlies X Number of hours worked per week, divided by 7 and divided by the number of beds at average occupancy rates (example: $\frac{12 \text{ staff} \times 40 \text{ hours/week}}{7 \text{ (days/week)} \times 8 \text{ (10 beds at 80\% occupancy)}} = 8.5 \text{ nursing hours per patient per day}$)

In home care, what is the number of patients carried per FTE:

	<u>Average</u>	<u>Maximum</u>	<u>Minimum</u>
Nurse _____ :	_____	_____	_____
Home Health Aide _____ :	_____	_____	_____
Professional Volunteer _____ :	_____	_____	_____
Social Worker _____ :	_____	_____	_____

What is the role of the referring physician in this hospice? (and what is the role of the Medical Director and other hospice physician, if any?) Is medical management of patients the responsibility of the Medical Director?

What is your hospice's criteria for patient admission? (please include variations, if any, for each hospice component.) (please supply copy)

Briefly, what is the procedure for admission (per component)?

What is the role of the family (or "significant others") in patient care?

What is the role of patients and/or families as team members or decision makers in their care?

Briefly, what is the procedure for maintaining medical records? (is problem-oriented charting used? _____) Is a pain chart used? _____ If so, is it maintained by patient/family or staff?

What are the procedures for follow-up and evaluation of the care provided (and of the degree to which the hospice is meeting its objectives)?

What are the quality assurance mechanisms that are operative here? (e.g., utilization review)

What is the average number of patients at any one time (per component) (also maximum and minimum over the past year)?

What is the average number of patients per month (per component) (also maximum and minimum over the past year)?

In home care, what is the average number of visits per day per nurse and per other care given (also maximum and minimum)? (In inpatient care: average number of patients per nurse per shift (and maximum and minimum)?

What is the number of visits each staff member above could carry? (for inpatient: number of patients per nurse, per shift) (Is this expected? _____ If so, when? _____)

What is the average length of stay of patients (per component) (and maximum and minimum)?

What is the average number of deaths per month (per component)
(also maximum and minimum)? (and place of death)

What are the dependency or "quality of life" ratings for patients (per component)?

What is the average age of patients (and maximum and minimum)?

What is the ethnic composition of the hospice's patient population?
(is language a problem?) How does this contrast with the community at large?

What is the religious/spiritual composition of the hospice's patient population? Does
this differ with the composition of the hospice staff?

Is geographical distance a problem (for patient visiting in home care or families
visiting patients in inpatient care)?

What percentage are private pay (billed and paid by patient/family)?

What is the hospice's policy and method of financing those unable to pay?
(what percentage of patients is this)?

How does hospice finance bereavement care and public education programs, if any?

What are the costs of care per day (inpatient) or per visit (home care)? (Is home visit cost a fixed rate or does it vary by profession?)

How does the hospice maximize reimbursement?

What, if any, changes in reimbursement and financing are planned or anticipated?

Other relevant information:

INTERVIEWEE NAME:	HOSPICE NAME:		
DEGREES, certificates, licenses PROFESSIONAL POSITION	DATE OF INTERVIEW:		
JOB TITLE:	INTERVIEWED BY:	SEQUENCE NO.	
How long have you worked here?	PAID:	PROF VOL:	LAY VOL:
Who supervises you?	% of time (full or hrs/wk)		

What do you do? (job description - % of time for each activity)

Whom do you supervise?

Are your responsibilities clear to you?

Why do you work here? (What factors drew you to hospice work?):

Did anyone close to you die before you worked here? (who, how long ago, how did you and those close to you handle it?):

What is the most fulfilling part of your job?

What part of your job do you feel you do best? (Your strengths)

What part do you like least? (Why?)

What is your supervisor's leadership style? What are his/her strengths and weaknesses?
(Is there staff review and feedback? Is it done on a scheduled basis?)

Is the system of discipline fair and equitably applied? (explain)

What are the goals of the hospice program here?

How do hospice goals relate to your personal goals? (do you entirely agree?)

Whom do you work with?
(team members)

Who does what?

How well do they do what they do?

Are you a team? _____ Does the team change for each patient? _____ If yes, what procedure is used to establish each team? Are there problems in establishing teams? _____ If so, how do you solve them?

Who are the most important people on the team?

Are all the team members clear about their individual responsibilities?

Are communications among team members clear? (Does information get lost?)

Do you all agree on your responsibilities, and on the purpose of the work?
On the priorities of each task?

Are the resources of team members fully utilized?

Are there problems between people of different professions on the team? _____ What are they and what do you see as the causes?

Have you incorporated new members into the team? Or lost a member? How do you and the team adapt to these changes? How do you help the new member to fit in?

How are problems solved concerning patient and family care? (What procedures are used?) How well do they work? How flexible are they?

How are problems solved between team members? (What procedures are used?) How well do they work? How flexible are they?

How are problems solved between team members and supervisor? (What procedures are used?) How well do they work? How flexible are they?

How does the team monitor and evaluate its progress?

How do you get along with the others on the team?

If there are problems, how do you handle them? How successful is your method of handling them?

* Once a care plan is developed, how easy is it to carry it out?

Once a care plan is developed, how easy is it to modify it if one team member noted a change?

How do the others on the team feel about each other? (working together, respecting each other, helping each other, expressing criticism/appreciation?)

How satisfied are you with the way the team functions? What aspects are good? What would you like to change?

Who is "top management"?

What are the strengths/weaknesses of "top management"?

What was your reaction to the first death of a patient you cared for here?

How adequate did you feel in comforting the family?

How did the other members of the team react to you at this time?

How did your supervisor react?

Has this first experience here affected you since (personally, and professionally)?
Did it carry over to your family? (Did you take it home?)

How have the more recent deaths of your patients affected your work? (particularly those you considered to be personal losses)

When are you told of a patient's death, if you were not on duty at the time?
By whom? _____ How? (How do you feel about it?)

How important is your religious conviction to you?

How important is the religious conviction of your patients and families in your caring for them (example: belief that suffering is atonement)?

Does your religious conviction affect your handling of death and dying issues? _____
How? How does it affect your work with patients and families?

What things make you uncomfortable in dealing with the spiritual needs of your patients and families? How do you help them?

How comfortable are you in caring for someone who is close to death who has no religious belief?

Do you seek assistance from other team members (or others outside your team) for spiritual areas? (for yourself or for patients/families)

What is your ethnic background?

When your cultural or ethnic values are different from those of your patient/families do you find it difficult to empathize with them? (How do you feel? How do you react?)

* What are the things that get in your way most when you try to individualize care?

Are there any other environmental things (e.g. program, policies, procedures, time restraints, shifts)?

* How do you react when patients refuse to cooperate with what is known to be best for them?

* How do you feel if you visit a patient at home, and neither the patient nor the home is clean? (How do you react?)

* How do you find out the patient's expectations/goals for the care process?

- * Who introduces the patient into the planning process? _____
What is your role in helping the patient to be adequate for this responsibility?
- * In the inpatient unit, do patients determine the timing of their daily routine?
_____ If so, what problems does this create?
- * What is the mechanism if the hospice caregiver and patient don't get along (especially in home care)?
- * How do you feel when a family insists on changing a wish of the patient (example; when the patient nears death, the family insists the patient be moved to an acute care setting for heroic measures)?
- * Is your feeling the same if the family wants to change a patient's wish when the patient becomes comatose?

* How do you feel when patients and families disagree with each other about what should be done (such as about the patient's care, the location of the care, or what the family should do after the death)? How do you react to the patient and to the family?

What are the things that really get to you and make you upset here?

Have you noticed any changes in your behavior or habits since you started here (sleeping, eating, gain or loss in weight, illness, emotions, way you feel about or treat other people)?

Do you live alone or with family/friends? _____

Who is your family?

Does your work affect your family life? _____ How?

Do your family members support you? _____ How?

Do you have hobbies and outside interests? _____ What are they? Whom do you do them with? Do they act as supports for you?

How do you handle the stress of the work on the job? What do you feel are the causes of stress for you? How do you deal with them? How successful are these methods? Do you feel you need help in dealing with stress?

When was the last time you saw a physician for a physical complaint? _____
What was the complaint?

Do you believe that this, or other physical complaints you have, are related to the stress of working with dying people?

What is your opinion of the training you received when you started here?
(job orientation)

What about on-going inservice education? How often is it provided? _____
What is your opinion of it? Does it meet your needs?

✓ How adequately do you feel you understand the following topics. How much training, if any, do you need in these topics?

	Have you had training (here or elsewhere)?	Has this proved to be sufficient in your present work?
description of humanistic patient care:		
comparison of this with conventional care		
knowledge of symptom control:		
knowledge of patient rehabilitation, physical restoration, maintenance of independence, activities of daily living, and self actualization (including the role of occupational and physical therapists):		
environmental factors that contribute to the level of success of the team and the individuals in it:		
awareness of the emotional problems involved in dealing with death:		
psychosocial implications of illness, death and aging:		
effect of religious beliefs and cultural background on patients' and families' reactions to death, illness and aging:		
skills in listening, teaching, group process, stress management:		

What other training, if any do you feel you need? (and what does the rest of the team need, if different?)

What opinions, problems and suggestions do you wish to add concerning your job, the hospice organization, the care of your patients and families, etc.?

Interviewee Name:	Hospice Name:
Hospice Affiliation:	Date of Interview:
How Long Have you Had this Affiliation?	Inter-viewed By: Sequence No.

Regular Positions(s) and Organization(s):

What are the goals of the hospice program here?

How do these goals relate to your own personal goals, and/or to the goals of the organization for which you work? What factors drew you to this relationship with hospice?

Do you find this relationship fulfilling/satisfying? _____ what are your problems with this activity?

Is this hospice program contributing to the community?

How well does the community feel its needs are being met?

Are referrals adequate and comprehensive?

What public support do you receive (dollars, volunteers, goods, etc.)? Is public support increasing? How satisfied are you with the amount and the rate of increase?

What are the major conflicts between the hospice and the community, (if any)? (the medical community, other organizations) How do you deal with them?

Do you think the community's view of the hospice program is correct?

Within the hospice program, are financial problems of major concern?

How good or bad is the relationship between the Board and the management of the program?

How involved is the Board with the staff? (Do Board members attend patient care conferences)

How do external constraints (such as reimbursement mechanisms and licensure regulations and requirements) affect the continuity of care?

How is quality of care maintained and improved?

Are there problems in obtaining and keeping the quantity of staff needed and the variety of professions needed?

Are there problems in obtaining and keeping and selecting the quality of staff needed?

Do the staff function as a team (or teams)? _____
Is team function difficult?

Are the educational needs of the staff met? _____
Is this a problem?

What are your future plans and hopes for the hospice program?

If you had \$5,000.00 to donate to the hospice today, for what would you most like it earmarked? Why?

What opinions, problems or suggestions do you wish to add?

Appendix G

- 01 Interviewee name
- 02 Degrees etc.
- 03 Job title
- 04 How long have you worked here?
- 05 Who supervises you?
- 06 What do you do? (Job desc. - %)
- 07 What are the things that facilitate your individualizing patient care?
- 08 What are the things that get in the way most when you try to individualize care?
- 09 Are there any other environmental things (e.g., program, policies, procedures, time constraints, shifts)?
- 10 Do you consider yourself part of a team?
- 11 If yes, which team?
- 12 Who are the members?
- 13 Does this team relate to other teams? Which ones?

PROBE

- Rehabilitation Team (Core)
- Hospice Home Care Team (VNA)
- Oncology Unit Team
- Management Team
- Other Teams _____

- 14 Is there a team that responds to bereavement needs of families?
- 15 Does the team change for each patient? If yes, what procedure is used to establish each team? Are there problems in establishing teams? If so, how do you solve them?
- 16 Are all the team members clear about their individual responsibilities?
- 17 Are the resources of team members and other personnel fully utilized?
- 18 Are there problems between people of different professions on the team? What are they and what do you see as the cause?
- 20 Distinguish between the role of the medical director of the oncology unit and medical director of the rehabilitation team as it relates to the terminally ill patient. How does this compare to the roles of attending or referring physicians? (If a terminally ill patient on the oncology unit has severe pain out of control, who does nurse go to?)
- 21 To what extent do the roles of differencing professions (as they relate to the terminally ill patient) overlap. i.e., Nurses, Social Workers, Chaplains, Psychologist, PT, OT, ST, etc.
- 22 What is the role of the patient/family on the team?
- 23-29 Insert program specific questions.

- 30 What are the procedures for:

- A. Admission of terminally ill patients.
Are there criteria?
- B. Discharge of terminally ill patients.
Are there criteria?
- C. Patient referrals to supportive services
- D. Patient referrals to the rehabilitation team.
- E. Patient referrals to the hospice team
- F. Transfer of Information
(i.e., shift to shift; inpatient to home, team to team)
- G. Attending physician involvement
- H. Follow-up.

- 31 Have you incorporated new members into the team?
Or lost a member? How do you and the team adapt
to these changes? How do you help the new member
to fit in?
- 32 How are problems solved concerning patient and
family care? (What procedures are used?) How well
do they work? How flexible are they?
- 33 How are problems solved between team members?
(What procedures are used?) How well do they work?
How flexible are they?
- 34 How are problems solved between team members and
supervisors? (What procedures are used?) How well
do they work? How flexible are they?
- 35 How does the team monitor and evaluate its progress?
- 36 Once a care plan is developed, how easy is it to
modify it if one team member notes a change?
- 37 When are you told of a patient's death, if you were
not on duty at the time? By whom? How? (How do
you feel about it?)
- 38 How are orders for ancillary personnel made? By
whom?
- 39 Are distinctions made in the care provided between:
- Cancer patients for rehabilitation
 - Cancer patients not for rehabilitation
 - Cancer patients who are terminally ill.
- How is it conveyed that such a distinction exists?
- 40 How are decisions made regarding patient care?
- 41 How is it determined who is in charge?
- 42 Whose patient is it?
- 43 How do teams interrelate?
- 44 Are patient/family conferences held on regular basis?
- 45 Are team meetings held on a regular basis?
- 46-49 Questions unique to program
- 50 What is the major goal of the rehabilitation teams?
for terminally ill?
- 51 What is the major goal of the VNA hospice program?
- 52 In a scale of 1-10 with 10=great need for training and
1=little need for training, where do you fall on the
following educational topic areas:

- A. Knowledge of symptom control
- B. Knowledge of patient rehabilitation and physical restoration
- C. Maintenance of independence, activities of daily living
- D. Awareness of the emotional problems involved in dealing with death
- E. Psychosocial implications of illness, death and aging
- F. Effect of religious beliefs, and cultural background on patients' and families' reactions to death, illness and aging
- G. Skills in listening
- H. Skills in teaching P/F
- I. Skills in group process
- J. Skills in stress management.